# PRIVATE PRACTICE IN CLINICAL PSYCHOLOGY

THEODORE H. BLAU

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# Private Practice in Clinical Psychology

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# Preface

AT THE TIME OF THIS WRITING, psychology as a science is nearing its one-hundredth anniversary. As a profession, psychology admits to adolescence rather than centenarianism. The development and progress of clinical psychology as a socially applicable profession is far more recent and is well-described elsewhere (*1*).

Although clinical psychologists have been "practicing" for over twenty years, appreciable numbers of independent and qualified practitioners have offered services to the general public for only a decade. Even the term *appreciable numbers* is a rather qualified one.

The past ten years have been marked by an increasing interest in what is loosely termed *private practice*. While the majority of well-trained clinical psychologists work in university or institutional settings, there is continual and growing interest in the offering of psychological services to the general public for a fee. There has been no commensurate increase in information or reports concerning principles or experience in private practice. Formal and informal discussions of this new area of endeavor at conventions and other professional gatherings sometimes result in strange ideas and mixed opinions.

A fairly large group of intelligent and capable psychologists, without any experience or direct observation of private practice settings, insist that only charlatans, money-grabbers, and unethical psychologists would consider operating in private practice. This attitude has even had some official and somewhat aggressive recognition in the not too distant past (*2*), rapidly followed by indignant and insistent rebuttal (*3*). Private practice *is* growing with psychology. Comparison of the 1955 and 1957 Directories of the American Psychological Association indicates not only an increase in the numbers of clinical psychologists, but a proportionately greater increase in those listing themselves as being in private practice.

Nowhere in the professional literature has there appeared, to date, a critical yet constructive analysis of private practice. The philosophical and ethical issues have been given considerable thought and analysis (*4, 5*). To date, however, the conditions of individual practice of clinical psychology in a community setting is a professional mystery except to those actively engaged in such practice.

The purpose of this book is to present an organized series of observations on the individual and responsible practice of clinical psychology. As might be expected of any professional writing, this book has its own point of view or bias. While the whole of private practice will not be delineated, this book will describe the private practice of clinical psychology based on six year's experience in this setting. Many psychologists will find procedures and methods with which they are unfamiliar or not in agreement. This tends to be usual in psychology, particularly in the clinical area. Such criticism is expected and desired. It is hypothesized that the methods to be outlined are realistic, ethical, needed, and, hopefully, effective.

The first portion of the book deals with the preparation for practice in the private setting. Part II considers the specific materials and procedures necessary in the private practice. Part III indicates what would seem to be necessary responsibilities of the

clinical psychologist who serves the community as an individual representative of his profession. Part IV deals with some of the practical problems involved in keeping informed of recent developments in the profession. An Appendix completes the volume, and here may be found forms and procedures which may help in understanding the details of the clinical practice being described, plus a directory of community services with which the clinical psychologist should be familiar.

Since I assume that clinical psychologists can function as practitioners, I shall have to meet the objections of some colleagues who feel that the knowledge from psychology as a science is insufficient to support psychology as a practicing profession. This issue was considered by the distinguished author and physician, Allen Gregg, in 1948 (*6*), who wrote, in the *American Psychologist*:

> . . . Psychology as a science as well as medicine must realize this inescapable sequence: Study discovers knowledge; Knowledge brings power: Power entrains responsibility, and Responsibility must be prepared to survive praise or blame, dependence or passionate resentment. One can see the sequence in the history of Physics, from Archimedes to the Atom Bomb; study, knowledge, power, responsibility. If this is the sequence of knowledge, in the physical world, can we expect the history of psychology to follow a different course? . . . It may be a tragic history, or it may be magnificent. Whatever its future may be, psychology will sooner or later have to face the responsibility that comes from power.

The time for responsibility in clinical psychology has arrived. In this country, three-quarters of a million hospital beds are occupied by emotionally-disturbed patients. The number of adequately or even inadequately trained psychologists, psychiatrists, and social workers is woefully insufficient to serve all those persons who need help (7). We accept the fact that childhood environment and experience determine much of adult adjustment or lack of adjustment. Although clinical psychology is the profession which has the most complete training in human behavior as related to growth and development, too few clinical psychologists are in community settings where their training and experience can

be adequately used in *prevention* as well as cure. I believe we have knowledge and power: We must now face the responsibility.

The ideas and experiences of many colleagues were used in preparing this manuscript. Harold L. Mittle, D.J., kindly reviewed and helped revise the chapter on psychologists and the legal profession. John P. Devlin made many helpful suggestions in his critical review of the initial manuscript and his help is gratefully acknowledged. Kenneth MacCorquodale deserves special note for his detailed review of the final manuscript. Lili R. Blau was helpful in the mechanical preparation of the manuscript but her primary contribution of continual encouragement is most heartily acknowledged.

The American Psychological Association has kindly given permission to quote from various issues of the *American Psychologist*. In each case the original source is cited.

T.H.B.

# Contents

## PART III

## PROFESSIONAL LIAISON AND RESPONSIBILITY



## PART IV

## ADDITIONAL CONSIDERATIONS

# Part I

# PREPARATION FOR PRACTICE

# CHAPTER 1

# The Candidate for Clinical Practice

BEFORE A DETAILED ANALYSIS of the functions of clinical psychologists in practice can be made, the background of the clinician must be considered. We differentiate psychologists by many prefixes, and even these bear careful qualification. Although we speak and write of "clinical psychologists" as a homogeneous grouping, we are aware that training, experience, and functions differ considerably. Some psychologists who deal specifically in projective techniques, in research, practice, or training are considered clinical psychologists. This is also true of psychologists who specialize in therapy.

## EDUCATION AND EXPERIENCE

Although disagreement exists as to what skills and armamentarium distinguish the clinical psychologist, unity has begun to emerge. The American Psychological Association, at the Boulder Conference on Training in Psychology (*8*) and in the functions

of its Education and Training Board, has succeeded in formulating a program which promises to provide standards of training in clinical psychology. At the last report of the Education and Training Board, forty-seven American universities and colleges offered approved Doctoral programs in this specialty (*9*). A synthesizing conference on training, similar to the Boulder Conference, took place late in 1958.

In 1953 the Committee on Private Practice of the Division of Clinical and Abnormal Psychology (now Division of Clinical Psychology) recommended standards for the unsupervised practice of clinical psychology (*10*). Since this book will be concerned with the general practice of clinical psychology, the entire set of committee standards seems applicable. The Committee recommended the following minimum standards for all psychologists engaging in this activity.

1. A Doctor's degree or its equivalent in clinical psychology based in part upon a psychological dissertation conferred by a graduate school of recognized standing.

2. At least two years of paid full-time experience, or its accumulated equivalent of paid experience, in the field of clinical psychology; this experience to be had under the direct supervision of a clinical psychologist of recognized standing. Included in this two years of paid full-time experience may be a maximum of one year's paid internship in clinical psychology.

3. At least one year of paid full-time experience, or its accumulated equivalent, in the field of clinical psychology in a treatment setting where mildly and seriously disturbed individuals are commonly seen (for example, a mental hygiene clinic, a mental hospital, a university clinic, or a child guidance clinic). This year of paid full-time experience in a treatment setting may be obtained in the course of the two years of paid full-time experience mentioned under Point 2, or it may be otherwise acquired.

The committee recommends the following additional standards for clinical psychologists engaging in the unsupervised practice of clinical psychodiagnosis (including mental testing, remedial diagnosis, the use of projective and nonprojective instruments, and the like):

4. At least fifty hours of direct supervision in any psychodiagnostic specialty which the psychologist utilizes in his unsupervised practice (that is, fifty hours spent with a supervisor in addition to time spent in actual testing). This fifty hours of supervision may be obtained in the course of the paid full-time experience mentioned under Points 2 or 3, or it may be otherwise acquired. To be acceptable, supervision in any psychodiagnostic specialty must be had under the direct supervision of a clinical psychologist or other professional worker of recognized standing in this specialty.

The Committee recommends the following additional minimum for clinical psychologists engaging in the unsupervised practice of any form of counseling, or psychotherapy (including marriage counseling, clinical vocational counseling, nondirective or client-centered counseling, psychoanalytic psychotherapy, and the like):

5. At least one hundred hours of direct supervision in any counseling or therapeutic specialty which the psychologist utilizes in his unsupervised practice (that is, one hundred hours spent with a supervisor in addition to the time spent with clients or patients). This hundred hours of direct supervision may be obtained in the course of the paid full-time experience mentioned under Points 2 or 3, or it may be otherwise acquired. To be acceptable, supervision in any counseling or psychotherapeutic specialty must be had under the direct supervision of a clinical psychologist or other professional worker of recognized standing in this specialty.

6. Anyone who engages in the unsupervised practice of counseling or psychotherapy should be aware of his own possible inadequacies, blind spots, and psychological traumatizations. To this end, it is desirable that he experience some type of personal counseling or psychotherapy himself with a clinical psychologist or other professional worker of recognized standing.

7. Anyone who engages in the unsupervised practice of counseling or psychotherapy should maintain open lines of communication with other professional workers with equivalent training and experience, and should especially communicate freely with medical and other professional consultants when he is treating patients or clients who may be seriously maladjusted.

There has been some argument as to the amount of training required for independent practice. It has been suggested that some

psychologists with only the Master's degree are capable therapists or diagnosticians. This may be true, particularly of subspecialists in clinical psychology or those who work in so-called part-time private practice. However, when a psychologist sets himself up in the community as a clinical expert in human behavior, he cannot demand that his clients bring him only problems which can be helped through the Rorschach test or client-centered therapy. Indeed, such practice is not private practice but rather a restricted subspecialty, available only for certain psychological problems and usually dependent for referrals on other professionals. This type of practice can be likened to something midway between the X-ray technician and the roentgenologist.

The independent community practice of clinical psychology requires a broad educational background in psychology as a science plus additional training in the use of the wide variety of tools and techniques relevant to the clinical psychologist of today. This preparation includes not only formal training, but experience with the variety of problems which are likely to be met in independent private practice. Unless the clinical psychologist is prepared to deal competently with planning for a mentally defective child, evaluation of a psychotic adult, the treatment of behavior disorders in children, the preschool evaluation of a child's capacity, the evaluation of parental roles, and a wide variety of other behavioral situations, he should not "hang out his shingle." An extensive background is essential to the recognition of these problems. Thus, the psychologist who has had minimal experience with seriously disturbed adults might say "I won't deal with these people." He is rationalizing his position at the expense of the good name of the profession of psychology and, what is worse, with the possible consequence of detriment to his patient. Unless adequate training and experience precede private practice, accurate assessment of one's skills and recognition of one's limits is almost impossible. Therefore, the Doctorate in clinical psychology from an accredited school, plus at least two years of supervised training and experience, should be prerequisite for private practice.

Eventually, American Psychological Association standards and legislative action at the state level will do much to establish minimal requirements for practice. The primary responsibility, however, will lie with the university graduate schools and training centers. This is where the professional psychologist is molded. Here the profession has the opportunity for guiding, training, and selecting competent representatives of clinical psychology. Standards should be established here. Those who enter private practice do so catch as catch can, and with the only apparent rule being "Let your conscience be your guide." It is hoped that this situation will be considered and rectified in the near future.

## AMERICAN BOARD OF EXAMINERS IN PROFESSIONAL PSYCHOLOGY

Though often considered, the diploma of this Board has not been accepted as a sole criterion for competence in performing unsupervised private practice. Many feel that the requirements of the Board are too stringent. It is rather generally agreed that those clinical psychologists who are able to meet the requirements are well qualified to practice clinical psychology independently.

Organized in 1947 and patterned along the models set by the certifying boards in other professions, the American Board of Examiners in Professional Psychology offers its diploma in three specialties: Clinical, Industrial, and Counseling. To date, over 1100 awards have been made to senior members of the profession under the "grandfather" provision. Over 300 diplomas have been awarded to candidates who have been examined under the requirements now in force. Requirements for certification by the Board are as follows:

1. Membership in the American Psychological Association and/or Canadian Psychological Association.
2. A Ph.D. degree in psychology from a college or university that, at the time the degree was awarded, met the existing standards of the American Psychological Association for

doctoral training in the specialty of the applicant or the equivalent as judged by the Board.

3. Five years of acceptable qualifying professional experience during which time the candidate shall have demonstrated superior performance. Four years of this experience shall be postdoctoral.
4. Presently engaged in professional work in the field of specialization.
5. Satisfactory endorsements.
6. Satisfactory performance on written and oral examinations.

The Board has prepared a statement entitled *Information for Prospective Candidates.* This pamphlet gives specific information on requirements for candidacy, fields of certification, the nature of acceptable qualifying experience, and evaluative procedures, including policies governing written and oral examinations. A copy of *Information for Prospective Candidates* may be obtained from the executive office of the Board in Carbondale, Illinois (*11*).

## AMERICAN BOARD FOR PSYCHOLOGICAL SERVICES

Initially sponsored by the American Psychological Association as a committee to compile a directory of psychological services in the United States, this Board now publishes an annual directory of agencies and individuals who have been evaluated and certified to perform psychological services for the public after meeting certain standards of quality and competence. Forms to be filled out by an individual or agency before evaluation include such items as the following:

1. Professional staff, qualifications, functions, and duties.
2. Utilization of psychologists, status, and responsibilities.
3. Sponsorship and source of financial support of the agency.
4. Chief purposes and problems handled by the agency.
5. Kinds of clients.

6. Fees and fee policy.
7. Decision-making and agency procedures.
8. Consultation facilities and practices in the community.
9. Referral system and practices.
10. Physical facilities.
11. Status of staff members with other comparable professional boards or certifying agencies.
12. Method of record keeping and protection of clinical material.

Details concerning functions and procedures of the Board are published regularly (*12*). Application forms are obtainable from the office of the President, 10 East Sharon Avenue, Glendale, Ohio. In all good conscience, the clinical psychologist in private practice should obtain an evaluation by this Board after a year in practice. If his application is not acceptable, efforts should be made to improve his professional adequacy until such approval is obtained.

## PRIVATE PRACTICE DEFINED

The term *private practice* may be used to describe a variety of the activities the psychologist engages in incidental to his vocation. The clinical psychologist employed by the Veterans' Administration or the community guidance center may see a few patients in the evening or on weekends. The university professor may have a few private consultations with patients. But private practice, as it will be discussed in the following pages, refers to full-time, competent general practice in a stable community setting. It is proposed that the psychologist offering clinical services for a fee must be willing to avoid a conflict of interests by devoting himself primarily to his practice in the community. He should integrate himself into the community as a responsible professional person, accepting the full-time role as a representative of the applied science of psychology.

# CHAPTER 2

# The Clinical Setting

## THE PHYSICAL SETTING

THERE SEEMS to be a popular conception among clinical psychologists who aspire to private practice that the physical setting is the least important of problems to be considered. In one respect this attitude is correct, in that office space, equipment, and telephones are readily available in most cities. On the other hand, setting up a two-room office, with a secondhand desk and the residual equipment from graduate school, the attic, and a good secondhand shop, is unrealistic. Although the basic commodities offered to the public are the psychologist's training, experience, and capacity, the surroundings or "container" for these are worthy of some note.

The selection of office site itself bears some consideration. Unless the practice is established in a small city where almost any location is accessible to the public, the patients' convenience must be considered in choosing the office site. Of primary importance is the availability of bus or other public transportation (especially helpful for child patients where the independent riding of a bus may be part of the therapeutic plan). Suitable parking space must also be available for patients.

It is generally wise to locate in a section of the city that is devoted to professional offices. Several considerations dictate this: When a physician or lawyer wishes to make a referral, the psychologist close at hand is often chosen. Location among other professionals also enables the clinical psychologist to make inter- and intra-professional contacts more readily.

If a choice is available, offices in a ground-floor location are to be preferred, being more convenient and safer with child patients. A fair number of adult patients will be encountered (hopefully, at the beginning rather than the end of their treatment) who prefer to avoid stairs, elevators, and heights. In addition to this, the soundproofing of offices and playrooms is much simpler in ground-floor locations. The worth of this construction modification is amply demonstrated by the case of a withdrawn child who begins to deal with his hostility by jumping on the playroom floor, only to be frustrated in this, directly or indirectly, by parental-like rebuke occasioned by the irritation of other tenants in the building.

Basic floor space required for general practice would include a *reception room*, *consulting office*, *playroom*, and *test room*. This may seem a generous allowance of space to many psychologists who have conducted their work in one small room in a temporary building on a campus or hospital. Yet, these are but the minimal accommodations to enable the general practitioner of clinical psychology to offer complete service. A reasonable estimate of the over-all space needed for these accommodations would be about 600 square feet, for which the clinical psychologist can expect to pay between four and five dollars per year per square foot, in the larger cities. This usually includes all utilities, air conditioning, and maintenance. The psychologist who is able to locate a suite of offices exactly meeting his needs will be most fortunate. One can usually expect to incur the expense for some construction work before the offices are suitable. Figure 1 shows an example of a recommended floor plan.

As shown in Figure 1, storage space and a place for the files are

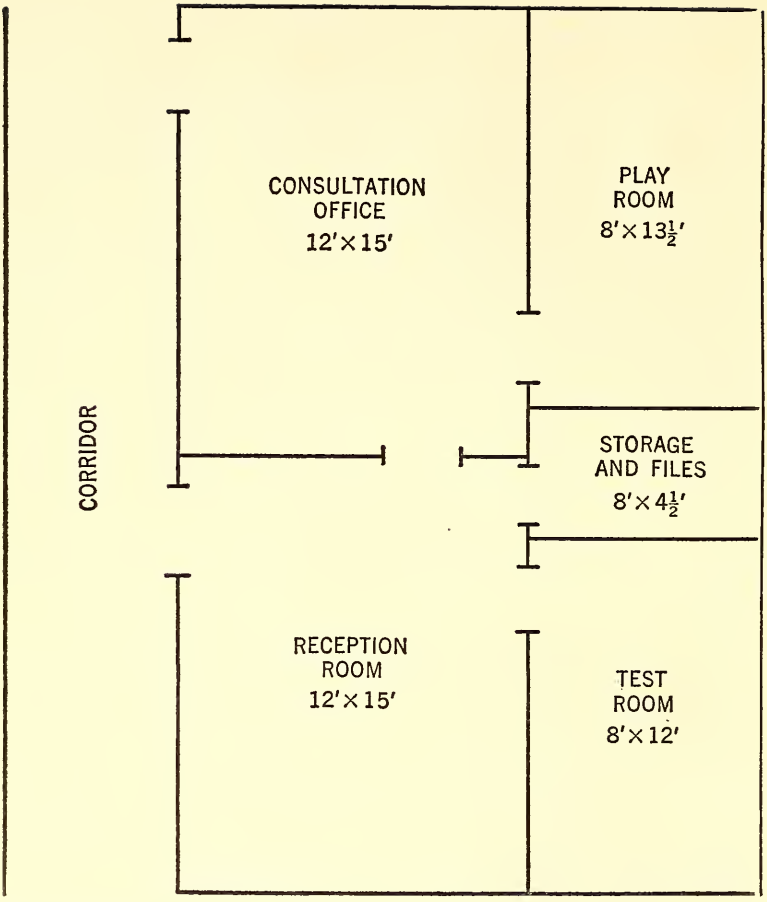


FIGURE I. A Recommended Floor Plan for a Suite of Offices for the General Practice of Clinical Psychology.

located in a convenient place, out of view of the reception and clinical rooms. The additional test room is an invaluable and necessary unit. Here the patient may conveniently take objective tests. It is also an excellent place for parents to read special material often referred to as part of a therapeutic program. Where complicated diagnostic procedures are planned, the material may be

prepared and administered without haste, leaving the consultation room free for regular appointments. Such a room proves well worth the additional rental cost.

## OFFICE EQUIPMENT

There is no standard way of furnishing a psychologist's office, but certain considerations are important. The reception room should provide seating for at least five people. The seating should be comfortable, durable, and separate. Comfortable and durable are self-explanatory, and separate is the way most of a psychologist's patients prefer to be seated.

The receptionist's work space should be placed apart from the seating arrangement so that appointments can be made, financial matters discussed, and the telephone answered with some degree of privacy. Although the receptionist should be able to see everyone in the reception room, a partial alcove is often convenient and valuable.

At least one steel file drawer with a lock is required for records. Additional storage cabinets are also helpful to provide for the miscellaneous equipment necessary for the operation of any office, small or large.

The size of office and elaborateness of furnishings will depend somewhat on the variety of functions. For example, if group psychotherapy is to be offered, more space and furniture are required.

## CLINICAL EQUIPMENT

Although the training and certainly the methods of clinical psychologists are far from standardized, a list of basic materials will be recommended. Aside from clerical equipment and play therapy materials, the psychologist's prime concern is with the instruments of diagnosis or evaluation. The following equipment is recommended:

INTELLECTUAL EVALUATION

*Wechsler Adult Intelligence Scale Kit*, with manual and record forms (*13*)
*Stanford-Binet, Form L Kit*, with manual and answer forms (*14*)
*Ammons Full-Range Picture Vocabulary Cards*, with manual and record forms (*15*)
*Cattell Infant Intelligence Scale Kit*, with manual and forms (*16*)
*Vineland Social Maturity Scale*, with manual and record forms (*17*)
*Grace Arthur Point Scale of Intelligence Kit*, with manual and record forms (*18*)
Stop watch

PERSONALITY EVALUATION

*Rorschach Plates*, with record forms (*19*)
*Thematic Apperception Test Cards* (*20*)
*Blackie Pictures* (*21*)
*Sentence Completion Test* *
*Draw-a-Person Test* *
*Minnesota Multiphasic Personality Inventory* Booklets and answer sheets (*22*)

INTRA-CRANIAL PATHOLOGY MEASUREMENTS

*Bender Visual-Gestalt* (*23*)
*Spiral Aftereffect Apparatus* (*24*)
*Grassi Blocks Test* (*25*)
*Graham-Kendal Cards* (*26*)

ACHIEVEMENT TESTS

*Gates Reading Readiness Tests* (27)
*Metropolitan Achievement Tests* (Primary I, Primary II, Ele-

* Preferred forms of these tests are easily mimeographed.

mentary, Intermediate, and Advanced. Covers academic achievement from Grades 1 through 7.) (*28*)

*Gilmore Oral Reading Tests* (*29*)

*Co-operative English Tests* (*30*)

*Stanford Achievement Tests* (7th through 12th Grade) (*31*)

The above can hardly be termed a comprehensive list or, in fact, a validated battery of "best" tests. The group listed, however, can be considered a broad sampling of the measuring instruments available for use in clinical practice. The extension or restriction of these will depend on the individual clinician's training and experience.

## THE ONE-WAY VISION MIRROR

Most training institutions maintain a room which contains a one-way vision mirror for the purposes of student observation, or for the evaluation of clinicians being trained in testing or therapeutic procedures. This has become such a valuable technique in training that the Education and Training Board of the American Psychological Association recommends that such an apparatus be available in all accredited training institutions.

The one-way vision mirror is also of practical use in private practice. Carefully installed between the clinician's office and the playroom, the one-way vision mirror offers an opportunity for the clinician to allow the parents of the child being evaluated to observe some part of the process. It has been found through empirical experimentation with this apparatus that when the parents are able to see and comprehend some portion of the diagnostic process, they identify with the process, and seem to accept it more readily. Too often a parent brings his child to the psychologist, gives a case history, and then is separated from the child for several hours, the parent later receiving an interpretation of "test results" without really knowing what went on. We too often assume that the parents accept entirely these "secret" processes that their youngster undergoes during the evaluation.

The size of screen recommended is eighteen inches high by thirty inches long. This generally gives a full view of the playroom setting. It is recommended that a small intercommunication system be made available so that the sound will also be transmitted from the playroom to the clinician's office. Such sound systems are inexpensive and easily installed.

Some care in installation must be observed. The mirror should be at such a height as to be not easily accessible to destructive children in the playroom. On the viewing side of the mirror, care should be taken so that it may be concealed behind a picture, bookcase, or by other means convenient to the clinician. Although the mirror should not be used injudiciously, it is found that with certain parents, particularly those who have difficulty in understanding or identifying with the diagnostic process, the mirror may well be the key to forming this valuable identification.

## STAFF

The clinician entering private practice may wish to begin with an extensive staff, clerical and clinical. But the beginner would be wiser not assuming the financial burden of a large staff. Group practice will be discussed later (see Chapter 15). For the present, the question of staff will be confined to the secretary-receptionist.

In the choice of secretary of the clinical psychologist (and other human behavior specialists as well) we often see an apparent lack of discretion. Very few professional men, including psychologists, seem to be aware of the necessity of careful selection of secretarial staff. The psychologist is aware that his clientele is made up of tense, frightened, and worried people. He further knows that first impressions on patients are lasting. Despite this, few psychologists "practice what they preach" in selecting their own staff. Some psychologists use their wives, cousins, nieces, or mothers as receptionists. Yet, others may deem it important enough to use an intelligence test as the basis of selection.

The receptionist-secretary is the first person to come into con-

tact with patients and colleagues in the majority of cases. She is the clinician's representative, whether the clinician desires this or not. In her hands lies the smooth operation, or turmoil, of scheduling appointments. In private practice all sorts of misunderstandings, time changes, cancellations, and adjustments occur. This can be a minor variation or a predominant theme in the clinician's life, to a large extent dependent on the person he chooses as his secretary.

Before a clinician selects a secretary he must consider all of the above and any other major tasks and responsibilities his secretary may have to assume. The following selection procedures have been found useful:

1. A personal data form
2. A personal interview
3. A standard typing test
4. An intelligence test
5. A vocabulary comprehension test
6. A numerical reasoning test
7. A clerical accuracy and speed test

A thematic projective test or two may be added to the above for more extensive evaluation of personality. At first inspection, this would seem a rather formidable battery for the selection of a secretary. The aspiring clinician must remember, however, that in private practice, *he*, not his agency, the "Board," or the administrator, is responsible for each error, minor or otherwise, that occurs from the time the patient makes contact with his office until he leaves. Certain clerical or personal errors by secretaries can be not only embarrassing to the clinician, but costly, or even dangerous. Errors of judgment can best be avoided by careful selection of clerical personnel. An example is warranted here:

The experience which led to the recommendation of these careful selection procedures concerns a young lady selected as a psychologist's receptionist, primarily on the basis of a personal interview. She was experienced, obviously intelligent, and verbally capable, even adroit. She was highly recommended. Two weeks after her employment began, she

received a telephone call from a woman who had been seen by Psychologist X for interview preliminary to diagnosis. The woman demanded to speak with Dr. X. The receptionist informed her that the doctor was in conference, whereupon the woman said, "Well, tell him I'm cutting my wrists," and hung up. The receptionist had failed to determine who was calling, but (she later explained) she was certain it was "Mrs. C . . . who acted very strange the other day." On the basis of this impression, she interrupted Dr. X and stated that Mrs. C was threatening suicide. Dr. X immediately called Mrs. C and receiving no answer on the wire, assumed it was a genuine suicidal effort. He then called a physician whose office was located near Mrs. C's house, with the result that the physician interrupted his schedule, hastily packed needles, sutures, and medication and rushed to Mrs. C's house. He met her just going in her front door, rather puzzled at this hurried-looking man with the little black bag rushing up to her. He asked if she were Mrs. C and, when so informed, he began to question her about suicidal tendencies, trying to clarify the strange circumstances. Fortunately, the woman who really called was not genuinely suicidal, but had used the threat as an hysterical, controlling maneuver. The net result of the secretary's error, however, was an irate and abusive physician, widely heard referring to those "crazy psychologists," an insulted patient, and one very embarrassed but well-meaning clinical psychologist.

The same secretary, after being criticized for her carelessness in not getting reliable information, decided to redeem herself by making a series of telephone calls to people who had scheduled diagnosis but had cancelled the appointments. She called twenty of these reluctant patients, giving them a "sales talk," and at the end of the day proudly announced to her boss that she had drummed up two cases. She had some difficulty understanding why the psychologist was chagrined to the point that he terminated her employment.

To some extent, these and other basic errors in judgment can be avoided by careful training in procedures, standards, and ethics. No amount of training can substitute for good judgment, and it behooves the practicing psychologist to select his secretary with care and discretion. This will be of benefit both to the patient and the clinician.

# CHAPTER 3

# Organizing the Practice

BEFORE THE CLINICIAN is prepared to accept appointments and begin his work, certain basic procedures should be well formulated and initiated. This will save confusion and anxiety for both the patient and the clinician.

The decision must be made as to the office hours which will be made available to patients. Although most professional people start their office hours at nine in the morning, it has been found that eight o'clock in the morning, although somewhat early, makes available a time which many patients can utilize well before going to work, or before going to school. The recommended office hours would be from eight to five Monday through Friday, and from eight to twelve on Saturday. The Saturday time is particularly desired by patients who work or are otherwise engaged during the week. Parents, in particular, prefer the Saturday time for children. Although it is possible for parents to take children out of school for appointments, they prefer non-school hours.

For the making of appointments, some sort of appointment book

will be valuable. A variety of these may be found at stationery stores, or the clinician may develop his own form to be kept in a looseleaf notebook by the secretary (see Appendix B). If the appointment book is properly constructed it can also be used as an accurate reference for bookkeeping, tabulating fees, and evaluating the case load.

Most appointments are made by telephone, and often directly to the secretary. For this reason it is wise for the clinician to instruct his secretary carefully in the procedure of handling telephone conversations. Where the patient calls and says "I would like an appointment to talk with Dr. Jones," the procedure is relatively simple. Most patients, however, when calling a psychologist, want to find out something about his services, as well as to express their basic problem. Whenever possible, the secretary should *not* handle this type of call, but refer it to the psychologist himself. At the time of the telephone call an intake sheet should be made out (see Appendix B for recommended intake form). In general, the information recorded should be the patient's name, address, telephone number, date of birth, and if spontaneously mentioned, an exact notation of what the patient says about his problem. The secretary should then be instructed to make an appointment with the patient for initial discussion with the clinician. If the patient is certain he wishes service, generally an hour appointment is recommended for the first discussion. If the patient is unsure of whether the psychologist can be of help, and does not wish to discuss his problem on the telephone, he should be encouraged to make a short information appointment with the clinician. It should be clearly specified that there will be no fee for this information appointment, since it will be mainly used to determine whether or not the psychologist can be of service.

When making application for telephone service, the clinician should be certain that he is able to receive a private line. This is necessary, since patients very often, though this is discouraged by the clinician, discuss personal and confidential matters.

When ordering a telephone, the clinician will be asked to specify

the type of telephone book advertisement he will use. The American Psychological Association has made certain recommendations as to telephone listings (*32*). Recently the Conference on State Psychological Associations has recommended that local psychological associations take a yellow page box listing in the telephone directory wherein each of its members may be listed. Should this type of listing not be available, the clinician in practice should list himself in accordance with the professional and conservative nature of clinical work. The name, highest degree, specific certification, address, and telephone number may be listed as follows:

**John Doe, Ph. D.**
Diplomate, Clinical Psychology, American Board of Examiners in Professional Psychology
1001 Chestnut Street Telephone 3–6972
**Consultation by appointment**

Professional people often announce the opening of practice, both to the general public and to professional colleagues. For an announcement to the general public a *professional card* is taken in the local newspaper. The recommended size for such a professional card is one column by one inch long. A sample form of this type of professional card is as follows:

**JOHN DOE, Ph. D.**
Announces the opening of offices for the practice of
**CLINICAL PSYCHOLOGY**
1001 Chestnut Street Telephone 3–6972
**Consultation by Appointment**

Most newspapers set a specific rate for a particular time period, usually thirty days, for the appearance of this card. The professional card is printed in various sections of the newspaper over the thirty-day period.

It is acceptable policy, and in good taste, to inform professional people in related areas about beginning the practice. The follow-

ing card, conservatively printed or engraved, in a size not to exceed three by five inches, is recommended.

**JOHN DOE, Ph. D.**
Diplomate in Clinical Psychology
American Board of Examiners in Professional Psychology
**announces the opening of his office for the practice of**
**CLINICAL PSYCHOLOGY**
1001 Chestnut Street Telephone 3–6972
**Consultation by Appointment**

The above card may be sent to psychiatrists, physicians, principals of schools, directors of agencies, and other professional persons with whom the clinician is likely to be associated. A wholesale distribution of such a card is not acceptable practice however. Distribution should be determined by selecting those *professional people in the immediate area with whom the clinician is likely to be associated in practice.*

Certain stationery is necessary for the proper conduct of a practice, and this should include letterheads, regular envelopes, confidential envelopes, billheads, billhead envelopes, appointment cards, and professional calling cards. Appendix B lists recommended forms for this stationery.

It is at this point, that many clinicians who enter private practice as a full-time venture begin to feel the pangs of disappointment. Ordinarily there is no rush of prospective patients seeking appointments and consultations. Unless the clinician is particularly well known in the city, and long and careful preparation has gone into setting up his practice, it takes some time before a regular flow of patients can be expected. The clinician can utilize this time to good advantage. Primarily he must be sure that he is adequately prepared in all the mechanical ways: equipment, space, and a secretary to handle his patients. Once this is done, he can begin establishing professional and public liaison for his practice.

Professional liaison usually starts, particularly for the clinical psychologist, with the other psychologists in the community and

with psychiatrists. Depending on how well he is known in the community, the clinical psychologist may well pay a formal call on each of the practicing psychiatrists in the city, to inform them briefly that he is in practice and is available for consultation. The psychiatrist may wish to know his qualifications, or to discuss the type of services that the psychologist plans to offer. The same type of visit could be made to individual psychologists in the community, and certainly prompt identification with the local psychological group would be advantageous (see Chapter 9).

If the psychologist intends to provide service for children, a visit to the principal of each elementary school in the community will make his availability known to the school authorities in case they wish to refer cases to him. Even though the school system may have their own psychological personnel, an immediate or specific problem occasionally arises where private consultation is required. Parents very often ask teachers or principals where they may take their child for specific services. Even in cases where the community has an adequate Child Guidance Center, appointments are often booked so far in advance that parents may prefer a private setting where they can obtain more immediate service.

The intake of patients, particularly on the self-referral basis, is to a large extent dependent on how well known the clinical psychologist becomes in his community. No ethical psychologist advertises himself as a functioning clinician, but the psychologist's name and functions become known to members of the community through his appearance before certain community groups. Most civic organizations are anxious to have speakers. The clinical psychologist by dint of his training and experience is in possession of knowledge and information which is of interest to lay audiences. It is for this reason that Rotary Clubs, Kiwanis Clubs, Parent-Teachers Associations, American Association for University Women groups, and the like, are generally eager to have the clinical psychologist as a speaker for their meetings.

Speeches before lay audiences must be carefully prepared, both in terms of the presentation of reliable information and the interest

value of that the material. Choice of topics must be selected with a view toward the interests or the needs of a particular audience, and particularly with regard to the time limit imposed by the group. Most civic clubs allow a speaker fifteen to twenty minutes and it is important that he respect any such time limit that may be imposed.

In the final analysis, the continuation and increase in referrals, after the usual slow beginning, will depend on the quality of the professional services rendered to the first group of patients.

# CHAPTER 4

# Patients and Their Problems

LITTLE HAS BEEN WRITTEN, or even discussed, about what a clinical psychologist in private practice does and who he sees (*33, 34*). There is, of course, considerable opportunity for the clinician to choose the kind of psychological work he will do. The nature of the case load will be somewhat determined by the way in which the clinician represents himself and of course by his particular skills. If, in addressing civic clubs, the psychologist consistently addresses these groups on the subject of "Achieving maturity in a changing world," he can expect more adults with emotional difficulties to seek service. When one is consistently pointed out as a "Child Psychologist," it encourages the referral of developmental behavior problems. Indeed, a significant portion of the psychologist's case load can be expected to involve developmental difficulties. This seems to be the result of the general public's tendency to associate "child" with psychology, and "adult" with psychiatry. Clinical psychologists in private practice can do much to dispel this notion.

## INTAKE PROBLEMS

Table I presents an illustrative rather than a broadly representative view of the patient population that can be expected in the private practice setting. The data are based on the cases of three clinical psychologists over a three-year period, involving 1200 referrals. Categorization is based on problem areas noted following evaluation. Frequently the initial statement of the patient or the parent of the patient may not indicate the fundamental evaluation problem. Thus, the parent's initial statement "Johnnie has been doing poor work in arithmetic for several years," may result in eventually discovering that the primary difficulty to be mental retardation, or deficit as a result of brain damage, or possibly emotional maladjustment, poor educational experience, or some combination of these. The primary problem sometimes turned out to be unwarranted parental anxiety.

In the following data, the percentages in various categories often add up to more than 100 per cent, since some referrals involved

TABLE I

PROBLEMS REFERRED FOR EVALUATION TO THREE CLINICAL PSYCHOLOGISTS OVER A THREE-YEAR PERIOD. N = 1200.

| | *Percentage of Total N* | *Percentage Where the Problem Was a Significant Element in the Total Situation* |
|---|---|---|
| *Child Referrals* Age 0–12 | 70 | |
| Adoption Evaluation | | 3 |
| Developmental Difficulties | | 50 |
| Preschool Evaluation | | 5 |
| Intellectual Evaluation | | 2 |
| Speech Difficulties | | 4 |
| Educational Problems | | 50 |
| Social Adjustment | | 60 |

| | | |
|---|---|---|
| *Adolescent Referrals* Age 13–16 | 5 | |
| Social Adjustment | | 75 |
| Intellectual Evaluation | | 5 |
| Educational and Vocational Evaluation | | 20 |
| *Adult Referrals* Age 17 and up | 20 | |
| Emotional Adjustment | | 90 |
| Marital Adjustment | | 40 |
| Vocational or Educational Difficulties | | 2 |
| *Miscellaneous* | 5 | |

multiple problems. No attempt was made to use standard nomenclature since the data are meant to be rather broadly descriptive.

## PROBLEMS INVOLVING THE CHILD

Approximately 70 per cent of initial diagnostic work involved youngsters. Child problems were classified as those involving the years from birth through twelve.

### *Adoption Evaluation*

Approximately 3 per cent of the children seen were for the purpose of determining intellectual level preliminary to placement for adoption. Public agencies, courts, and in some cases private physicians requested this service. Generally the children were between six and eighteen months of age, although requests for evaluation of eight- and nine-year-olds are occasionally received. In such cases, personality evaluation is often requested.

### *Developmental and Behavior Problems*

Involving children between two and seven years of age for the most part, the initial statement of problem often expresses the

parents' anxiety about the child's thumb-sucking, bedwetting, eating and sleeping habits, response to siblings, discipline, and the like. MacFarlane and associates (*34*) have clearly indicated the type and frequency of children's developmental behavior problems in both a normal and clinic-referral population. About 50 per cent of all child referrals involved some developmental behavior disorder, either as the primary problem or specifically indicated in the clinical history.

### *Preschool Evaluation*

A relatively new area for the clinical psychologist, about 5 per cent of intakes involved a request to evaluate the youngster before he entered the first grade. Often the parent had read articles in the popular periodicals about "reading readiness," "emotional preparation for school," or "should your child start school at six." Evaluation of the child's intellectual, emotional, and developmental capacity and achievement was requested. This area represents a growing use of clinical psychology as a planning tool or "preventive" rather than the classical "curative" or remedial role psychologists have too often chosen or of necessity been forced to share with the psychiatric profession.

### *Intellectual Evaluation*

Where school systems have their own staff of psychological workers, only about 2 per cent of private clinical intakes involved purely a measure of intellectual function. Most of these referrals resulted from a parent being informed by school personnel or physicians that the child was "mentally defective," or in some cases, "a genius." The clinical psychologist in this situation is consulted to substantiate or refute the initial evaluation.

### *Speech Difficulties*

Despite the fact that a very limited number of psychologists practice speech therapy, about 4 per cent of referrals were initiated as a result of, or included as a primary symptom, various speech

disorders. Whether the etiology is distinctly organic or not, psychological evaluation is usually helpful in planning remedial programs. Evaluation by a qualified speech pathologist is required as the major consultation in such a diagnostic process.

### *Educational Problems*

About 50 per cent of the children seen, regardless of the original reason for referral, had educational difficulties. Approximately 30 per cent of the children had specific problems relating to their academic adjustment. Poor attention span was the most frequent single symptom, and the range of educational difficulties was considerable. In the primary, elementary, and junior high school grades, reading skills seemed to be primarily affected.

Whether the educational difficulty preceded emotional distress, or vice versa, must be determined through the psychological evaluation.

### *Social Adjustment*

Most frequently involving children beyond the age of six, this complaint was often specified in terms of the youngster's reaction to his peer group, acting-out behavior, poor sportsmanship, inadequate response to discipline and direction, or simply, "he lacks self-confidence." The initial problem is seldom stated in exactly these terms. The parent may have brought the child in on the recommendation of a teacher, physician, or interested relative. The parents may express a good deal of concern over their child's "not growing out of it" as expected. The problem to be grown out of may have been poor arithmetic skills, chronic tardiness at school, inability to take responsibility at home, or simply "shyness." It is interesting to note that many of the behaviors and reactions which fall into this category are considered highly significant indices of immaturity and inadequacy by psychologists, psychiatrists, and social workers. Though it is in this area that most questions are asked by lay audiences, at speeches, rarely did initial intake complaints fall into the social maladjustment category. When these

problem areas were brought out during the history interview with parents, all too often the parent would explain "We've been told not to worry about that . . . his teacher says he'll grow out of it." The need for continued and intensified teacher education and the dissemination of public information concerning the background and development of emotional disorders is strongly supported by these observations. Approximately 60 per cent of all child intakes indicated difficulties in this area.

## PROBLEMS INVOLVING THE ADOLESCENT

Arbitrarily defining adolescence as the ages thirteen through sixteen, approximately 5 per cent of intakes were accounted for by this group. This is not to indicate that the "teen" ages do not have their share of difficulties or psychological needs. To the contrary, psychological services are probably too seldom requested for this group. The considerable popular literature on adolescence seems to have assured parents that, regardless of the reaction, if behavior disorders occur in adolescence it is "normal rebellion" or some other phase of development that will soon disappear. In some respects this is a helpful attitude, since parents seem more accepting of the painful initial attempts at maturity so necessary in the later stages of the developmental process. When this acceptance includes little or no concern about car theft, breaking and entering, vandalism, and narcotic addiction, acceptance has overextended its usefulness.

Seldom was the appointment with the psychologist made by the adolescent himself. Whereas children are brought to a psychologist, sometimes reluctantly, sometimes willingly, the adolescent almost always enters the situation with considerable resentment. Suspicious and unfriendly toward the "headshrinker," he is often openly hostile toward the parent for exposing him to embarrassment. The following indicates the more common referral problems among adolescent patients.

### *Social Adjustment*

About 75 per cent of the adolescent referrals included this complaint. The lack of adjustment may have been as mild as, "he would rather work on his automobile than his schoolwork," or in one case, as serious as murder. Most court referrals involved this age group.

### *Intellectual Evaluation*

Only about 5 per cent of adolescents were referred for evaluation of intellectual capacity. Most of these involved the question whether to continue in an academic course in high school, whether preparation for college entrance was a realistic goal, or validation of previous test findings.

Simple referral for an intelligence test at this age often reveals situations indicating recommendation for complete educational or vocational counseling.

### *Educational and Vocational Evaluation*

Although the schools in many communities maintain departments of guidance and counseling, 20 per cent of the adolescent intake involved questions of school adjustment, curriculum choice, or vocational and educational planning.

Parents may wish to plan well in advance for their youngsters by bringing them for evaluation in the ninth or tenth grade. Aside from evaluating the capacities and potentials of the youngster, the psychologist is often called upon to co-ordinate planning for recommended courses, special schools, follow-up, and the like.

## PROBLEMS INVOLVING THE ADULT

Considering adults to be those patients seventeen years of age and older, approximately 20 per cent of all referrals fell in this group.

*Emotional Adjustment*

Approximately 90 per cent of the adults who requested psychological services expressed difficulty involving social adjustment, feelings of inadequacy, inadequate emotional response or capacity. This covered the range from mild feelings of inferiority to full-blown schizophrenia. Contrary to previously published findings, (*36*), only about 5 per cent of the adult intake load could be classified as psychotic. Most of those were referred by physicians or psychiatrists for either a general evaluation or corroborative diagnosis.

*Marital Adjustment*

About 40 per cent of the adult referrals stated this to be their problem. Only 8 per cent sought specific help through "marital counseling," even when this function was known to be an available service. The interpersonal difficulties in the marriage were sometimes brought out by the patient after the interpretation of the diagnostic findings.

*Vocational or Educational Difficulties*

About 2 per cent of adult referrals requested help in these specific areas.

## MISCELLANEOUS PROBLEMS

Making up about 5 per cent of the adult intake population were those requesting certain specific diagnostic or evaluative services. These were services commonly performed by some clinical psychologist, but quite often a request was made requiring the legitimate use of psychological tools in situations a clinical psychologist might not ordinarily expect to make a contribution.

*Psychological Effects of Physical Damage*

Certainly not a new area for the clinical psychologist, occasional consultations were requested by specialists in internal medicine

concerning the psychological aspects of medical cases. Neurologists referred brain-injured patients for an evaluation and prognosis of the psychological symptoms involved in chronic and acute brain syndromes. Cardiac specialists asked for aid or recommendations as to residual capacity and rehabilitation potential in certain cardiovascular disorders.

In conjunction with medical experts, occasional requests were made of the clinicial psychologist to testify as to the psychological effects of trauma or disease in legal proceedings. The legal profession is becoming much more aware of the position of the psychologist as a human behavior specialist and expert witness (see Chapter 13).

*Performance Evaluation*

Included in this category of referral would be examination for "sanity" and competency as requested by a court. Federal, state, or local agencies, including the police and the military, requested evaluations of personal adjustment of key officers, executives, or other personnel, either as a selection measure or sometimes as an aid in the determination of appropriate disciplinary action.

Certain schools require a psychological evaluation preliminary to the enrollment of a student, and occasionally referred the prospective student for such work. Some theological seminaries have recently begun to request a personality evaluation as part of the application procedures for prospective ministerial students.

As the lay and professional public becomes more aware of the availability and usefulness of psychological services, even greater variety and frequency of these "unusual" referrals can be expected.

## SOURCE OF REFERRALS

Referring to the same group of patients previously discussed, Table II indicates where they came from.

TABLE II

SOURCE OF REFERRALS TO THREE CLINICAL PSYCHOLOGISTS OVER A THREE-YEAR PERIOD. N = 1200.

| *Source as Indicated by Patient* | *Percentage of Total Intake* |
|---|---|
| Self-referrals | 58 |
| Agencies and Schools | 8.5 |
| Psychiatrists | 7 |
| Other Physicians | 15 |
| The Courts | 1 |
| Ministers | 0.5 |

The category of Self-Referral perhaps conceals more than it reveals. Close questioning revealed that very few patients came in as a result of the psychologists' listing in the telephone book. Most of these people heard about psychological services from a neighbor or relative who had received such service. Others heard a psychologist speak at a Parent-Teachers Association or Mental Health Meeting and were thus motivated to seek help. Still others had discussed their problem with a physician, minister, or teacher in terms of "I know someone who . . . and they don't know what to do about it," with the recipient of this ill-disguised subterfuge recommending professional help. It was somewhat pleasantly surprising to find that over half of the Self-Referrals resulted from recommendations by former patients, perhaps indicating that people who consult psychologists are not completely prone to deny this.

## DISPOSITION

The initial efforts of the clinical psychologist concern the investigation and delineation of the patient's problems. The final test of the effectiveness of this work is the disposition of the evaluation, that is, recommendation made as to the form of treatment, if any. Later chapters will discuss the rationale and methods involved

in disposition. Table III presents the disposition of the sample of cases presented in this chapter.

TABLE III

DISPOSITION OF REFERRALS AFTER EVALUATION
N = 1200.

| *Disposition* | *Percentage of Total* |
|---|---|
| Interpretation, Recommendations and Follow-up Only | 40 |
| Adult Psychotherapy (Individual) | 50 |
| Adult Psychotherapy (Group) | 10 |
| Child Psychotherapy | 10 |
| Psychiatric Treatment or Hospitalization | 10 |
| Miscellaneous Referral | 5 |

Miscellaneous referral includes recommending the services of special agencies such as the Council for the Blind, the Crippled Children's Commission, the Vocational Rehabilitation Program, the Alcoholic Rehabilitation Clinic, and the like. It will be noted that the percentages total more than 100 per cent because of multiple disposition in some cases.

It is interesting to note that the bulk of referral problems noted in Table I concerned children, but the majority of therapeutic endeavor, as seen in Table III, was with adults. More often than not, a child evaluation will lead to treatment recommendations for the parents. This follows the general conception among students of developmental psychology that the parent is the significant factor in a child's emotional development.

## LIMITATIONS OF PRACTICE

The data discussed in this chapter cannot be generalized to all private practice settings. Various factors determine the nature and content of the case load, many of which are under the control of

the individual psychologist as indicated earlier. The nature of referred problems varies considerably from month to month and year to year. The data presented here merely indicate the variety and range of problems to be met in the community setting. It is the responsibility of the individual psychologist in private practice to accept and deal only with those cases for which he is adequately prepared by training, experience, and capacity.

# Part II

# CLINICAL FUNCTIONS AND PROCEDURES

# CHAPTER 5

# Evaluation: The Collection of Data

WHEN SOMEONE CALLS the clinical psychologist for an appointment, it can be assumed that stress, an emotional problem, need, or drive is operating. The patient hopes the psychologist will be helpful in solving his problem. Knowing that an appointment is likely to be for this purpose, the clinician must be prepared to play an evaluation role. Generally referred to as diagnosis, evaluation, or assessment, the process involves the examination of the patient, his problem, and his environment, using the special skills and tools at the disposal of the clinical psychologist. The process by which patients arrive for their appointments and proceed through evaluation is worthy of some detail. In few institutional settings does the psychologist see the patient first. In the private practice setting, perhaps more than in any other, the psychologist is primarily responsible for the patient and the clarification of his problem. Little of the psychologist's usual training and experience has prepared him to meet patients when they make their initial request for help.

## THE INTAKE PROBLEM

The initial contact with the psychologist as a professional person has been called the *intake process*. It is at this time that the first appointment is made, usually by telephone, through the mediation of a secretary-receptionist. The secretary's function should involve no more than the recording of pertinent information, such as name of the adult or child to be seen, birthdate, address, telephone number, and an indication of what the prospective patient says spontaneously about the problem. Exceptions to this would be direct referrals from certain agencies or from other professional persons, where this information is already available. In such cases, the appointment is being made for specific evaluation services (see Intake Form, Appendix B).

Ordinarily a one-hour appointment should be made before further scheduling occurs. Where the case involves a child, it is wise to schedule the initial appointment with the parents only, with evaluation of the child to follow the history-taking conference.

Occasionally, the prospective patient is unsure of the service he needs or wishes. Perhaps he would like to discuss the problem with the clinician before committing himself to any service. It is wise to offer a short information conference without charge, to determine whether service can be offered or accepted. Occasionally questions can be answered directly by the clinician over the telephone (for example, "Do you give memory courses through hypnosis?"). Whenever the discussion becomes involved in any way, an information conference is called for. Preliminary opinions or advice should not, of course, be given over the telephone.

## THE CLINICAL HISTORY

This volume has to this point dealt with the rationale and conditions of private practice for clinical psychologists. The present chapter, however, is methodological. No attempt will be made to discuss the relative merits of projective techniques, schools of psy-

chotherapy, or the reliability of intellectual evaluations. Since the final results of the evaluation process must often be presented in terms of realistic, environmentally-oriented recommendations, a rather thorough knowledge of the patient's previous history is vital.

The clinical history should always precede the scheduling of any diagnostic process. The causes of emotional or psychological disturbances are so varied that scheduling a series of tests on the basis of a short statement of the problem is ordinarily poor practice. While many clinical psychologists do not take clinical histories as a matter of course, this function is essential in the private practice setting.

The purpose of the clinical history is to provide the clinician with a range of subjective reports and observations of the patient, given by the patient himself or an informed relative. The history might well be called "the outside picture." Eventually, it is the psychologist's job to determine the "inside picture" and compare the two with a view toward conclusions and recommendations. Aside from the basic intake information, the clinical history should cover specific areas, with some variance depending on the age and stated problem of the patient. The following general areas should be covered:

### *Statement of the Problem*

In order to make the interview more comfortable for the patient, it is wise to allow the problem to be expressed in the patient's own words before detailed questioning begins. In some cases, the verbatim response is a clear-cut statement of the difficulty, while at the other extreme, the clinician may have to do considerable listening and summarizing. Usually some statements will be made which indicate predisposing factors.

### *Family Background*

Essential diagnostic and etiological information can be expected in this section of the history. Some detailed inquiry is called for concerning the parents, siblings, and children, where applicable.

Ages, dates of decease and cause, present whereabouts, occupation, personality traits, early influences, and social roles should be determined. A specific form may be used or the inquiry can be informally directed by the clinician. Particular attention should be paid to expressed or implied family influences on the patient, positive or negative. This section should cover marital as well as parental factors in the patient's experience.

### *Birth and Developmental History*

Although this part of the clinical history is an extension of the family history, it deserves attention. A separate section is suggested because of its temporal remoteness yet significance in the patient's life history and adjustment patterns. Detailed inquiry is required, beginning with pre- and post-natal conditions and extending through the significant motor and learning situations of childhood. Particular attention should be paid to any unusual retardation or acceleration of expected developmental patterns. When a child history is to be taken, it is wise, as standard procedure, for the secretary to instruct the parents to bring their "baby book" if available, which can be expected to contain valuable, fairly accurate observations of early behavior. It is at this point in the history that the birthdate, originally recorded by the receptionist, should be checked with the history-informant. This is particularly important where intelligence evaluation will occur. It is not infrequent that different dates are given, requiring clarification.

### *Medical History*

No attempt is made, of course, to determine the physical condition of the patient from a medical point of view, but the relation of physical illness to patterns of development, behavior, and learning is often of significant etiological value. The name of the patient's regular physician should be asked at this time, and the date of the last complete physical examination determined. It is at this point that the patient should be directed to have a physical

examination with a physician of his choice, before the completion of the evaluation process. A written report of this examination should be requested.

A complete description of the circumstances of any illness or treatment procedure likely to have had a behavioral effect on the patient should be obtained. Incidents of chronic headaches, gastrointestinal disturbances, fainting spells, dizziness, loss of attention span, and the like should be recorded. Clarification of these situations should be requested from the examining physician, where pertinent. In making the medical referral, the type of information indicated above is usually welcomed by the physician. Unless the case is referred to the psychologist for a specific evaluation procedure, a report of a recent medical examination should always be obtained.

### *Educational History*

The length of this section will vary with the referral problem and age of the client. With most adult patients, a brief evaluation of the educational and employment history may be made. Where the problem centers around educational factors, particularly in child evaluations, detailed questioning is indicated. Number of schools attended and particularly deviant periods should be noted. Teachers' comments, attitude toward school, acceleration or retardation of grade level and adjustment patterns may be evaluated at the discretion of the clinician.

### *Environmental History*

Again, the detail here will depend on the age and problem being considered. Early social patterns, parental roles in discipline and guidance, development of responsibility, interpersonal capacity, early and later interests and abilities, and the general circumstances of the home and community may be reviewed. An estimate of the socioeconomic, religious, and moral atmosphere of the early as well as present environment should be recorded. Significant changes and effects should be questioned in detail. Details of work and leisure-

time activities and associations often prove helpful in the over-all evaluation.

*Behavioral Deviations*

Recent studies (*34*) have indicated that behavioral traits formerly considered "neuropathic" or predictive of emotional diffi-

TABLE IV

AN AGE SCALE FOR TABULATING DEVELOPMENTAL ANOMOLIES

*Personal Adjustment*

| *Age in years:* | *0* | *1* | *2* | *3* | *4* | *5* | *6* | *7* | *8* | *9* | *10* | *11* | *12* | *13* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Nail biting | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Crying | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Thumb sucking | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Enuresis | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Tics | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Somnabulism | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Vomiting | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Stuttering | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Masturbation | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Nightmares | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Night terrors | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Fearful | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Cruelty | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Tantrums | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Destructiveness | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Quarrelsome | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Jealous | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Unco-operative | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Excess compulsive | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Excess energy | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Lying | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Stealing | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Shyness | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Dependency | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Lack self-confidence | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Withdrawn | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |
| Mood swings | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. | .. |

culty occur normally during certain periods of development. For this reason it is important that the ages and intensities of occurrence be recorded. Table IV shows a form convenient for the detailed inquiry and later evaluation of some common behavioral deviations. Using this form, the informant should be asked if the patient now exhibits, or has ever exhibited, the particular trait. An attempt should then be made to determine over what period of time the trait was observable. It is necessary to define the trait in terms which are meaningful to the informant. Almost every clinician has had the experience in asking for the incidence of masturbation, of receiving a bland "no," later to have the informant indicate ". . . and he always plays with himself," followed by a detailed description of compulsive masturbation. Continual presence of the trait is indicated by a solid line, while a broken line through the appropriate age range would indicate mild or intermittent symptoms.

This completes the basic clinical history. At this point, the clinician should ask the informant if there is any other information which would be of help in understanding the problem or the person. The informant occasionally brings up a point or two here, which indicates that no clinical history is ever a "complete" one.

Although the completeness and validity of any clinical history will depend on the communicative capacity of the informant, much responsibility lies with the clinician. His responsibility is for sound background training and experience, and a capacity to establish rapport effectively. Thorough training in psychodynamics, developmental psychology, and the social processes is essential before the clinician can ask the proper questions and analyze the informant's responses. A capacity for warmth, acceptance, and empathy on the clinician's part often helps the informant to overcome tension or reluctance in giving complete and meaningful information. The clinical history is the beginning of the diagnostic process to be sure, but it can also influence the patient's attitude during the testing, interpretation, and even the subsequent therapeutic process. The interpersonal process during the clinical history sets the stage

for future psychological work with the patient. A rushed, sloppy, caustic, indifferent, or patronizing history interview is a major clinical error.

The psychologist working independently and directly with the patient offers advantages over the "team" approach generally found in mental health and guidance centers. In the team setting, the patient may tell his story to a receptionist, then repeat it to a social worker, in detail, and then again to a psychiatrist. Unless reports of the first interviews are available at the time of testing, the psychologist may again request the "story." Despite the many advantages of the team concept, too many patients complain, perhaps rightfully so, "Everybody asks me to tell them my problem but who is going to help me?" Patients gain a feeling of comfort and confidence when they know that the first clinician they see will work with them through the entire process.

## SPECIFICATION OF THE PROBLEM

At the conclusion of the clinical history, the psychologist should be in a position to specify the presenting problem in terms of the direction in which the examination will proceed. It is at this point that the clinician should determine the initial battery of tests to be administered, as well as the reports that should be obtained from agencies, schools, and other professionals who have known the patient. Appointments should be made for the clinical examination, and if possible, a date set for the interpretation of the results. After some experience, this can be done at the time of the clinical history. Inexperienced clinicians will find it more efficient to set the interpretation date at the completion of the clinical examination.

## THE CLINICAL EXAMINATION

In any setting dealing with an extensive range of problems, the capable clinician soon learns that there is no "standard battery of tests." To be sure, certain clinical tools tend to be more valuable

than others in arriving at conclusions or hypotheses regarding patients.

The complaint is often heard that psychiatrists view clinical psychologists as "psychometricians." All too often this attitude develops in response to psychologists labeling themselves in terms of a single test which is defended as though it inherently had the mechanical reliability of a calculator, and the integrity and perceptiveness of a Supreme Court judge. *The only value in any test is the capacity of its user to discern and apply its stimulus values adequately.* Neither the Rorschach nor the Thematic Apperception Test is the "best" test of personality. The Wechsler series aren't "better" than the Stanford-Binet. Indeed, neither one may be as adequate or appropriate as the Progressive Matrices or the Ammons Full-Range Picture Vocabulary Test. The value of a test lies in the person selecting and applying the test, hence the emphasis on *specification of the problem* in the previous section. Unless a clinician feels capable of fitting his clinical tools to the problems faced by his patient, rather than because of the awe he holds for any test, he had best not foist his limited psychological skills on the unwary patient in the independent private practice setting. Where a great range of problems is to be met and evaluated, an essential professional prerequisite is flexibility. To illustrate:

A five and one-half year old girl was referred by a local pediatrician. He stated, "The school says the child is retarded but I would like this checked." Indeed, the youngster walked in an ataxic manner, exhibited chorea-form movements of the hands, and verbal response was minimal. The school psychologist reported a mental age of two years, four months as measured by the Stanford-Binet. Shortly thereafter the child was tested at the local Child Guidance Center, with a resulting Wechsler Intelligence Scale for Children Full-Scale IQ of 48. The two evaluations were in close agreement and a diagnosis of "Mental Deficiency, Imbecile Type, Exogenous (brain-injured)" was made. The detailed clinical history revealed no specific circumstances to indicate encephalopathy. The family situation, however, was very stressful during the child's developmental years. During the clinical examination, while a Critical Flicker-Frequency Test was being administered, with little apparent attention from the child, she suddenly remarked, "The

light is flickering." Routinely noted as a remark during testing, we were suddenly aware that this supposedly defective, brain-injured child had exhibited appropriate verbal behavior compatible with a mental age of eight years. Careful evaluation during several examination periods indicated many of these unusually appropriate behaviors. Neurological and electroencephalogic examination was requested and revealed no evidence of organic pathology. A tentative diagnosis of childhood schizophrenia was followed by intensive psychotherapy for the child, as well as for the parents. At the end of six months, a Full-Range Picture Vocabulary Test revealed an IQ of 115. After two years of the family program, the youngster, still under intensive treatment, had started school, and was beginning to read. The original plan to place her in the state institution for mental defectives was, of course, abandoned.

It is the psychologist's responsibility to make available to the patient *all* of the skills he has acquired as a specialist in behavioral science. He must prevent, as far as possible, the too-frequent errors based on good tests and poor judgment.

No attempt will be made to recommend types of tests or methods of examination since this in itself is worthy of many volumes. Certain criteria may be helpful, however, with general reference to psychological examination of patients and of specific import to the private practice setting:

1. *Relation to the Problem.* Based primarily on the specification of the problem as developed from the referral source and the clinical history, the tests chosen should be, at least potentially, capable of providing information that can be related to the difficulties experienced by the patient. Unless the question of intellectual capacity seems related to the stress being considered, a full Wechsler Adult Intelligence Scale for every patient over sixteen years of age is superfluous to the examination and expensive for the patient.

2. *Relation to the Patient.* It is the responsibility of the clinician to know both his tests and the nature of the patient sufficiently to avoid administering those tests which may give a false picture of the patient. Thus, although the Draw-A-Person Test is probably somewhat applicable as a projective technique to all persons, it is

hardly the most appropriate procedure when examining a commercial artist or magazine illustrator. Despite the fact that many states specify the Stanford-Binet as the instrument for evaluation when considering institutionalization for mental deficiency, it would not be the appropriate single instrument to measure a child with a severe speech defect or patient of hyphenated-American background where English has not been the predominant language of the environment.

3. *Investigate the Range of Causality.* A single test can reveal, *or conceal,* the cause of the difficulty. There are multiple causes for most behavioral difficulties. The clinical psychologist will best serve his patients and his role by being prepared to investigate, or have investigated, multiple or indistinct causal relationships. A child who has consistently done badly in school work, has repeated several grades, and who is found to have a Full-Scale Wechsler IQ of 76 could well be suffering from defective hearing, not significant enough to be discovered by the parents, teachers, or physician. In this case, an audiometric examination as part of the total evaluation could materially influence not only the choice of psychological tests, but perhaps the child's future.

There can be no complete set of rules for psychological tests or procedures. In all cases, judgment and flexibility are essential to the adequate evaluation of psychological problems.

# CHAPTER 6

# Evaluation: Reporting

WHEN THE DATA have been collected, the patient has been seen, observations made, and tests given, this material must be in some way made operational to deal with the patient's problems. The psychologist is expected to distill his procedures, and make some statements about the specified problem.

The format and effectiveness of clinical reports varies considerably. Some psychologists give a series of tests, come to some conclusion, and report their findings verbally. The protocals are then either discarded, or placed into a clinical folder of sorts. Other psychologists write extensive reports indicating the nature of the procedure used, the behavior of the patient during this procedure, and the interpreted results. To some extent, each clinician will develop his own methods of reporting his observations and findings. A written report ordinarily is a vital part of the evaluation function. Often in the private practice setting there is a necessity for reviewing the information or forwarding a report, one, two, or even five years after the patient was initially seen. Not only is it a laborious

job to make up a report after such a span of time between examination and evaluation, but the effectiveness of such procedure is questionable. It has been said that nothing is colder than a Rorschach protocol several years after administration. In any event it is recommended that following an evaluation, the psychologist make a written report of his findings to be filed as a permanent record.

## THE NATURE OF CLINICAL REPORTS

The actual mechanics of writing clinical reports will not be discussed here, as they have been covered in detail elsewhere (*37*). The nature of clinical reports, however, is worthy of consideration at this time.

The purpose of the report is to offer some explanation and usually some recommendations concerning the psychological problems which brought the person for examination. There has been much discussion and research concerning the validity of clinical instruments; it will be assumed that such clinical instruments are capable of valid use in the clinical setting. Reports based on psychological evaluation will in general contain three kinds of clinical information: *fact*, *assumption*, and *opinion*.

### *Fact*

The actual performance of the patient in the clinical setting, whether it is the psychologist's general observation or the test response, provide the facts that are included in the report. Such things as the Full-Scale Wechsler IQ, the observed behavior of the patient during the test situation, the number of hours the patient spent completing the Rorschach Test, and so forth, make up what we could broadly consider facts. Facts in and of themselves generally describe the exact observations of the clinician or the behavior of the patient. In and of themselves they are relatively useless in solving problems. They are, however, the basis for the solution of psychological problems, since upon these data are based the final recommendations.

### *Assumption*

Assumptions develop directly from the facts observed during the clinical examination. On the basis of research, clinical training, and experience, the clinical psychologist is able to broaden and interpret the facts resulting from the clinical evaluation. Most projective techniques lean heavily on assumption in the interpretation of the patient's behavior and response to the stimuli. Assumptions are more subject to invalidity and bias than facts, and it is for this reason that *a series* of tests and observations are often administered. A series of equivalent assumptions, resulting from facts observed in different settings, adds to the validity of the final integrated assumptions.

### *Opinion*

The making of clinical opinions is perhaps the most invalid of all the reporting done by clinical psychologists. It is, however, the most important aspect of the evaluation process. Facts and assumptions seldom, in and of themselves, add either understanding or amelioration to the problems faced by the patient. It is still necessary for the clinical psychologist to review his facts and assumptions, and render clinicial opinions as to the meaning of these in terms of the patient's psychological processes, past and present, together with some estimates of probable future response. Explanations of past behavior, diagnostic formulation, and prediction of future operating capacity all fall in the area of opinion. This is a *necessary* role of the clinical psychologist who offers his services to the general public. Because of the opportunity for bias and error in this area of reporting, it behooves the clinical psychologist to exercise the utmost caution and conservatism in the making and expressing of opinions concerning patients.

## DIRECTING THE REPORT

In clinical psychology there is a great deal of concern about who receives what reports, and how meaningful these reports may be.

Whereas a certain psychological report might be very meaningful when rendered to another psychologist, it may be garbled or misleading to a referring physician, or to the judge of a Juvenile Court. This would lead to the question whether a special report form should be made up for each individual who is to receive a report, so that their comprehension is thereby assured. If this were to be the procedure, a half a dozen different reports might be made up on each case, since often as many as six people or agencies may receive a report of the psychological findings. It is believed that a basic form for the psychological report is possible. This would include the observations of the patient's behavior, a discussion of the tools and techniques utilized in the evaluation, a listing of the facts resulting from the evaluation, development of a group of assumptions based on these facts, and finally recommendations based on the findings. Rather than writing a different kind of report for each recipient, based on this person's capacity to understand psychological information, the covering letter attached to a standard report would function as a synopsis or editorial note. The recipient's attention would thus be directed to portions of the report which were of particular interest, an interpretation would be given those portions of the report which may be beyond his training and experience, and he would be encouraged to consult the psychologist should any of the material remain unclear. Using this method of forwarding written reports permits a flexibility which is not allowed by simply forwarding a "type" of report to a "type" of person. As the clinical psychologist practices and becomes experienced in his community, he will become more aware of the limitations of the professional people with whom he deals. Based on this experience, he may fashion covering letters to more effectively communicate diagnostic findings.

As an example of this reporting method, consider the case of a thirty-two-year-old executive suffering from a peptic ulcer who was referred for evaluation by a physician after several months of unsuccessful treatment involving medication and dietary regime. The clinical history indicated that the gastric condition began

after the patient had been promoted to his present position of weighty responsibility after working under direct supervision for many years. In part, the psychological report read:

. . . The projective techniques indicate the presence of strong but inadmissible dependency needs. This, together with an inability to identify with authority figures, results in hostility toward his employer and guilt about his performance. The peptic ulcer would appear to be the defense against the conscious expression of the conflict.

The covering letter to the referring physician read as follows:

Dear Dr. Jones:

Thank you for referring Mr. Richard Roe, one of your patients, for psychological evaluation. Enclosed you will find a copy of my report. As you will note, paragraph three of page two indicates that Mr. Roe had a rather difficult time with responsibility all of his life and his new job has placed stress on him that he is not yet able to handle.

The evaluation indicates that if Mr. Roe were to have an opportunity to discuss and come to understand his fears in relation to this job as well as the other matters referred to, he would be in a better position emotionally to respond to the medical treatment of his gastric condition. You will note that I have recommended brief, intensive psychotherapy for this purpose.

Should you have further questions about the psychological evaluation on Mr. Roe, I would be pleased to hear from you. Thanking you again for this referral I am

Cordially yours

John Doe, Ph.D.

## REPORTING TO THE PATIENT

Clinical psychologists have received little training in reporting the results of psychological examinations directly and verbally to the patient, or the responsible guardian. Yet, this is the person who is generally designated as the responsible party in carrying through recommendations, or following a specific program. Reporting of results to the responsible party in the situation is the culminating aspect of the evaluation procedure. Although a differential diagnosis may be important when a case is referred for this purpose

alone, the psychologist in private practice will be asked to evaluate total personalities, to help in some way either the individual himself or his legal guardian. Unless a face-to-face reporting is scheduled and carried through, the clinician will rarely know whether the patient or the responsible party has comprehended the results of the evaluation.

It is the responsibility of the psychologist to know something about the patient or his guardian in terms of his capacity to accept and utilize the psychological findings. The level of communication between psychologist and patient will vary considerably. For instance, one can expect to range rather far and wide in the interpretation of a group of psychological tests to well-educated parents who are having their six-year-old evaluated before he enters the first grade of school. On the other hand, the interpretation of test results can be expected to be rather simple, straightforward, and repetitive when recommending the need for hospitalization to an adult patient who has been found to be acutely schizophrenic. *The clinical psychologist must never shirk his responsibilities in reporting his results to his patients.* Certainly discretion and caution must be used in the reporting of data to the patients, and at no time should the psychologist report data which are likely to be more harmful to the patient if expressed than if withheld. Too often, however, clinical psychologists, because of their lack of experience in reporting directly to the patient, have some anxiety as to how their report will be received, and as a result either avoid or give but brief attention to much of the data found in the psychological evaluation. Only experience and training in the area of reporting to the client is helpful in developing a capacity to deal with this problem.

## CONFIDENTIALITY

In all cases where applicable, the client should be reassured from the very beginning of the confidentiality of the evaluation contacts. Very often, however, the case is referred by an outside

agency, physician, psychiatrist, or other individual. Although a report must of necessity and through courtesy be sent to such an individual, the psychologist is responsible for discretion.

It is questionable, for example, whether a clinical psychologist should accept a referral from the mother of an alcoholic adult who is sending her son in "to find out if he is really crazy," and asks for a written report to be given to her and no report to the son. Although most clinical psychologists are well aware of the ethical standards involved in dealing with individuals (*38*), sometimes the clinician unknowingly injures his patient by sending a complete technical report to an individual who is not professionally or personally capable to use such a report properly. Some physicians, after receiving the technical report, will turn it over to the patient for reading. If the clinical psychologist has any doubt about the attitude of a referral source toward his reports, it should be discussed tactfully yet rather directly. In cases where physicians, lawyers, school agencies, and so forth persist in turning over the actual report to the patient, or who in other ways misuse the technical report submitted by the psychologist, service to such an agency or individual should be terminated, with the full understanding on the part of the agency or individual as to why he can no longer call upon the psychologist for services. This is a rare thing, however, since most people seem willing to listen to and accept the psychologist's recommendations on how his data should be handled. It is, of course, a wise policy to carefully stamp all technical reports "Confidential," with some brief statement that the report should be made part of the patient's record and not exposed directly to the patient.

## FOLLOW-UP OF INTERPRETATION

It is recommended that in each case where possible the clinical psychologist make arrangements to give the patient himself, or his guardian, an interpretation of the findings of the psychological examination. This procedure takes from one to two hours, and the

patient or the parents ordinarily sit quietly, intently absorbing what the psychologist has to say. It is rare that an individual at this time will ask many questions. Regardless of the results they generally seem to accept them.

It has been found, however, that after leaving the psychologist's office, the patient or his parents may have a great many questions arise concerning the report, the patient's behavior, and many of the recommendations. For this reason, it is usually worthwhile to schedule an *additional* interpretation session at a time several days to two weeks after the first interpretation. This has been found to be an effective means of more thoroughly communicating the evaluation to the patient or guardian. Patients seem much more comfortable about accepting psychological findings when the interpretation period is lengthened to two sessions. In rare instances three, four, or five sessions are necessary. Beyond this, of course, it becomes a counseling or psychotherapeutic situation.

A large number of patients who either bring themselves or their children for psychological evaluation receive a series of recommendations to be followed in the home, with no specific referral for any treatment process. In such cases it is always a wise policy to set an appointment, ranging anywhere from one month to twelve months in the future so that the patient may return and review the recommendations as well as discuss what has occurred in the interim. Most patients are not only willing but anxious to accept this follow-up procedure. From the psychologist's point of view this is an excellent opportunity to assess the validity of his "opinions."

# CHAPTER 7

# Therapeutic Functions

CONSIDERABLE DISCUSSION has accompanied the growing question of clinical psychologists practicing psychotherapy without direct medical supervision. Seldom is the well-trained clinical psychologist's ability to handle therapeutic functions seriously questioned, but his long-term individual responsibility, particularly in the private practice setting, is seriously attacked by some (*38, 39, 40*). Attitudes range from mild chastisement (*41*) to direct accusation of usurpation of function (*42*). Although some internal factions exist, the basic issue seems to be the difference of opinion between spokesmen of the psychiatric and psychological professions. A condensation of the published views follows.

## THE PSYCHIATRIC VIEW

*The independent practice of psychotherapy is strictly a medical function.* The training of clinical psychologists is said to be in-

sufficient for the independent dealing with the range of emotional problems to be found, either diagnostically or therapeutically (*43*). The psychiatrist, being a medical man, is the only person sufficiently and appropriately trained to accept the grave responsibility necessary in performing psychotherapeutic functions. This capacity for taking responsibility is said to be endowed in the psychiatrist by virtue of medical training. A corollary of the above view indicates that psychotherapy is the treatment of an illness, therefore, emotional disorders are to be treated in a medical setting. The fact that the mind-body dichotomy is conceptual rather than actual indicates that the workings of the mind should be in the domain of those who are concerned with the workings of the body (*41*). Patients in psychotherapy frequently require drug therapy. Clinical psychologists certainly cannot prescribe the necessary physiological treatments in these cases (*44*). In addition to the fact that traditionally and legally the practice of psychotherapy belongs in the domain of the Doctor of Medicine, when practiced independently, it is suggested that the psychologist lowers himself by giving up his essential role in research for the less noble practice of the art. In effect, the clinical psychologist loses his status as a scientist when he enters the independent role of psychotherapist (*45*).

It should be made clear that a good many members of the psychiatric profession feel that clinical psychologists are very capable psychotherapists, if adequately supervised. Other psychiatrists feel that the role of the clinical psychologist is that of laboratory technician. Both views are sometimes expressed by the same author (*46*).

Certainly the medical-psychiatric point of view is clear and the more convincing because of its succinctness. The essential issue would appear to be that the practice of psychotherapy is a medical function, and therefore should not be practiced by anyone other than a doctor of medicine.

## THE PSYCHOLOGIST'S VIEW

*The issue is very complex.* In general, psychologists believe that the practice of psychotherapy on an individual basis is an acceptable goal for the well-trained clinical psychologist. There has been some adverse comment published (*45*) and unpublished by members of the psychological profession who oppose their colleagues' participation in the independent or private practice setting. Highlighting their comments are such items as the dangers of the attraction of high income, the lack of research facility and productivity in the private situation, and the tendency of the person practicing independently to lose his ethical standards in response to commercial callings. A single article, cited in the Bibliography, attempts to answer these questions in a presentable manner (*47*).

Over the past few years, psychologists themselves, both clinical and nonclinical, have responded to the objections made by the medical profession in various publications. Today psychotherapy is generally considered to be a learning or relearning situation and not primarily a medical process—legally, scientifically, and in actual practice. Psychotherapy by psychologists has been and is being performed extensively and independently (*48, 49, 50, 51, 52, 53, 54, 55*).

Training for clinical psychologists has been formalized whereby acceptable minimal standards for the practice of psychotherapy on an independent and responsible basis can be met. This practice necessarily includes diagnostic or evaluation functions (*56, 57, 58, 59*). Certainly the psychologist, as a result of his training and education, generally is prepared to take a deep responsibility and ethical concern for his patient relationships (*60*). The clinical psychologist and the psychiatrist often work together when such a relationship is called for by the needs of the patient. Medical clearance is an integral part of the individual practice of psychotherapy by the psychologist. The psychiatrist himself often uses this procedure, preferring a general medical practitioner to do the medical evaluation of his patient. This also applies in many instances to the

administration of drugs, since it is often to the advantage of the patient not to receive his psychotherapy and drug therapy from the same individual. Insofar as the evaluation of his own capacity to handle a patient relationship is concerned, the psychologist, with his specialized evaluation tools and techniques, is perhaps in a better position to evaluate or diagnose the contribution of behavioral disorders to a given problem, and to consequently recommend remedial procedures.

Insofar as the psychologist and his role in research are concerned, the clinical psychologist ordinarily is the member of the "mental health team" in the best position to do adequate research, particularly in the area of psychotherapy. It is puzzling, however, how the clinical psychologist is expected to do this research, if he is deemed incapable of carrying out the therapeutic function in order to make his initial empirical hypotheses. If he cannot deal in this situation on his own individual responsibility, he probably is not capable of understanding or evaluating the function. Individual responsibility is the necessary factor preliminary to an adequate grasp and understanding of the process of psychotherapy. This, in itself, poses a problem in the training situation for the clinical psychologist. Many of the clinical professors at graduate schools have had very little actual, long-range practice in the functions which they present to their students. There is some logic in the idea that unless clinical psychologists can practice psychotherapy over a long-range period of time on an independent basis, they certainly should not be teaching or doing research in psychotherapy. Perhaps if well-trained, research-oriented clinical psychologists had greater opportunity for extensive and intensive practice of the psychotherapeutic function, we would see more basic and integrated research in this area than has been produced to date.

Clinical psychologists, as specialists in human behavior, have an ethical and socially beneficial professional function in the investigation, delineation, and amelioration of emotional distress or need. Inherent in this belief is that professional trust be given to the clinical psychologist's competence to use his judgment and ethical

discretion in the decision as to whom he shall deal with and to what extent on an independent basis.

## PSYCHOTHERAPY AND COUNSELING

Differentiation by definition does not always guarantee validity, and so it is with these terms. *Psychotherapy* is the name sometimes given to regular, long-term meetings dealing with the more severe emotional problems at a deep psychodynamic level. The term *counseling* is sometimes applied to direct advice-giving, planning toward specific goals, or dealing with emotional problems in a religious setting. It is obvious that both situations cover analysis and adjustment of human behavior in one form or another. Definitions in this matter are certain to be arbitrary and of limited value.

There are a number of "schools" and methods concerned with the conduct of regular patient sessions for the purpose of modifying individual reaction patterns. Research indicates that no one method achieves consistently better results than any other. Rather, the experience and training of the therapist seems of greatest importance in determining the effectiveness of psychotherapy.

For purposes of this discussion, psychotherapy will be defined, again quite arbitrarily, as the regular, goal-oriented contacts between the therapist and his client, with the purpose of developing insights and awarenesses which will enable the client to more effectively deal with existing emotional stresses. Whether the method is purely psychoanalytic, client-centered, or eclectic, certain practical problems and principles must be considered, with particular reference to the private practice setting.

## SUITABILITY FOR PSYCHOTHERAPY

It remains the responsibility of the therapist to determine whether a person and his problem are likely to be amenable to psychotherapy. A complete evaluation should precede the beginning of psychotherapy. Although some schools of thought allow

that psychotherapy should proceed without diagnostic evaluation, this would seem to be an unnecessary therapeutic error. The purpose of the diagnostic evaluation is not merely to devise a label for the problem or the person, but to investigate the etiology, nature, and amenability to change which exists as part of the individual personality. Any information which can help us to structure the plan of treatment is valuable and such information should be obtained from the preliminary evaluation. No rigid limits can be set as to which cases can be dealt with effectively, since the knowledge of the limits of psychotherapy is as yet far from complete. Certain suggestions as a general framework may nevertheless be helpful.

No case should be accepted for psychotherapy where other forms of treatment are primarily indicated. Where the problem requires medical treatment, rehabilitation procedures, intensive hospital or institutional treatment, psychotherapy should not be substituted. Since the psychologist has at his disposal the tools and techniques of measuring human behavior, this error should be rarely made.

Except under unusual circumstances, and with certain children's problems, psychotherapy should not be instituted without the agreement of the patient. Psychotherapy taken under duress is probably more harmful than helpful. At times, the patient's initial contacts are characterized by resistance. If the therapeutic relationship continues in this way, it is the clinician's responsibility to terminate the contact until the patient is able to accept psychotherapy.

When the therapist feels his experience or training is too limited or insufficient to proceed effectively, it becomes his responsibility to transfer the case to the specialist who is likely to be able to provide the appropriate setting for the patient's needs.

In deciding whether psychotherapy is the treatment of choice, the psychologist, aided by his diagnostic findings, must make some estimate of the patient's motivation, assets, and debits. These must be compared against the psychologist's own capacity, and a deci-

sion made. It is here that the psychologist's good clinical judgment, personal maturity, and careful attention to ethical standards will serve the patient best.

## STRUCTURING FOR PSYCHOTHERAPY

It has been said that it is impossible to give a clear picture of the nature and meaning of psychotherapy. This may well be true, but it is often helpful in initiating the process to structure certain ideas and concepts about psychotherapy for the patient's benefit. This clarification formulates the initial therapeutic atmosphere. The length and detail of structuring should depend on the patient's anxiety in regard to the therapy.

The actual physical arrangements of therapy, such as time and place, should be indicated. Whether contacts are to be once, twice, or three times per week should be discussed. The therapist should indicate the length of the clinical hour (usually 50 minutes). If notes are taken, the therapist may wish to explain the purpose and use of the notes to the patient. Reassurance should be given the patient that what transpires at these meetings will remain confidential.

It is often helpful, at the beginning of psychotherapy, to indicate that the value system of therapy will be the patient's and that ideas, incidents, and expressions will be considered for their emotional, not moral, value.

Some therapists have found that a brief comment concerning resistance is in order preliminary to the initiation of therapy. A statement indicating that as deeper feeling arise, a need to avoid these will occur, bringing about "resistance," and at this time the patient will be encouraged to express all of his feelings. The therapist's role will be to help him understand and utilize both negative and positive attitudes to further the psychotherapeutic program. Structuring should be simple and concise.

The success of therapeutic methods depends upon the patient expressing his ideas, thoughts, and feelings rather freely. At his

discretion the therapist may indicate during the initial contact that this is expected and necessary.

The therapist will often find that patients have a need to telephone him, either at his home or at the office, to discuss problems which arise spontaneously or to continue discussions that began in the last therapy hour. These calls are of importance at all times, whether they represent the patient's subtle resistance or constitute a real emergency. The nature of telephone calls is easily discernible after two or three have been received. If the basis is resistance, the patient should be encouraged to discuss and analyze these needs during the therapeutic hour. This may have to be done rather firmly. It is, however, a necessary setting of limits. If the calls are genuine emergencies, and continue, the therapist may have made an error in beginning psychotherapy as the treatment of choice. At this time hospitalization should be considered and discussed.

The question of regular appointment times is of importance. The patient who continually changes appointment times, calls at or after the appointment time apologizing for a forgotten appointment, and the patient who is chronically late constitute a group of people who are perhaps frightened of therapy despite the fact that they have accepted the procedure superficially. These consistent errors about appointment times are not-so-subtle forms of resistance and manipulation. As with frequent telephone calls, the behavior must be brought out and analyzed in the regular therapy sessions.

At this point, a note of caution is necessary. This resistance is a normal and frequent occurrence in therapy. It is the psychotherapist's responsibility to recognize and utilize resistance as a part of the process of psychotherapy. The therapist who develops a vengeful attitude toward offenders and attempts to punish them is playing a role destructive to psychotherapy. It is therefore wise that during the initial phases of psychotherapy (all through the process to be sure!) the psychotherapist honestly structure himself for the pitfalls of negative counter-transference and counter-resistance.

## MAINTENANCE OF CASE RECORDS

As there is no one perfect psychotherapeutic method, there is probably no best way to keep records of psychotherapeutic progress. Such records are an essential part of the process and should be attended to regularly and conscientiously.

The continuing notes of the sessions provide the therapist with a roadmap of the ground which has been covered. Every therapist should review progress at regular intervals in order to insure a full awareness of the process and material being covered. Every therapist is fallible and a regular review of the case record is helpful in discovering meaningful patterns of expressed behavior which may have been missed the "first time around."

Some therapists prefer to take notes during the therapy hour. They usually provide themselves with either a special notebook for each patient, or utilize special sheets which may be included in the clinical folder (see Appendix B). Few therapists take verbatim notes, instead preferring to note down significant expressions and interpretations. Most therapists develop one form of shorthand or another to facilitate the process. Snyder[1] has developed a helpful set of symbols for the description of patients' verbalizations during the therapy process.

The problems raised by this method are multiple. At the beginning, some patients express concern about the notes. Also, if the therapist is too fervent in note-taking, he will miss some of the visual cues and expressive behaviors which can be an important part of the therapeutic behavior of the patient. Both of these criticisms are more meaningful for beginning psychotherapists. Those clinicians who have settled on this method seem able to handle the two problems, the first by utilizing the resistance to further the cause of therapy, and the second by developing the capacity to take notes with primary attention to the patient.

[1] Although developed originally to classify nondirective responses, the system is applicable to almost all psychotherapeutic contexts. Snyder, W. U. An investigation of the nature of nondirective psychotherapy. *J. Gen. Psychol.*, 1945, 33, 193–223.

Another method of keeping case notes is summarizing interviews. Some therapists do this every five sessions or so. It is probably better practice to summarize at the end of each session. This, in fact, is one of the important reasons for the fifty minute hour in therapy. The remaining ten minutes before the next appointment is sufficient, in most cases, for the summarization of the proceedings of the completed session.

One of the most important reasons for the maintenance of adequate and complete case records is that the material may be forgotten, to the detriment of the patient. Some patients terminate therapy, and then several months or years later decide to continue treatment. Some patients are transferred to other therapists. In any event, the therapist has a responsibility to be able to reproduce a description of the therapeutic process if this is required.

The case record is, of course, important when consultation, collaboration, or referral situations occur. *The more adequate the case records in psychotherapy, the more meaningful will be the role they may be called upon to serve.*

## SUPERVISION AND CONSULTATION

All therapists require supervision and consultation. The more experienced the psychotherapist becomes, the less supervision he needs. Consultation, however, is a continuing need. The idea of a perfect psychotherapist who seldom, if ever, makes errors is ridiculous. It is for this reason that practice under solitary conditions without intraprofessional stimulation should be discouraged.

Every psychotherapist should have a regular opportunity to bring up problems and questions with well-trained colleagues. Staff meetings, consultation with other psychotherapists, and continual review of case records are essential aspects of practice. These meetings are usually stimulating as well as helpful.

Whether the consultant is a psychiatrist, a social worker, or another psychologist seems unimportant. The opportunity to review methods, procedures, and approaches is vital. In all probability, a

clinical psychologist should not undertake psychotherapeutic functions until such avenues of communication are available.

## TERMINATING AND TRANSFERRING CASES

On occasion it will be necessary for the clinical psychologist to transfer a case to another psychotherapist. The patient may be in need of hospitalization or psychiatric treatment for acute distress. Whenever in doubt, immediate consultation and referral are indicated.

Patients may move and request referral to a new therapist. The psychologist then has a responsibility to help the patient select a new psychotherapist. Use of the directories of the American Psychiatric Association, American Psychological Association, American Board of Examiners in Professional Psychology, American Board for Psychological Services, and Psychiatric Clinics of the United States (Appendix A) is most helpful. Generally, the patient should be given the names and addresses of several psychotherapists the psychologist considers will be qualified to continue the case. The patient should be made aware that a change of therapists may be difficult at first. The patient should be informed that upon selection of the new therapist, the patient may write giving permission to his previous therapist to forward a summary of his records to enable the therapeutic process to continue in light of the work to date.

At times, resistance, transference, counter-transference, or other factors may arise in such intensity and with such little chance of resolution that a transfer of therapists is indicated as a necessary step for therapeutic progress. When this occurs, it is the responsibility of the clinician involved to help the patient arrange the change to a new therapist. Experience indicates that this situation occurs about once in each fifty cases.

Regardless of the reason for a change of therapists, the change should occur efficiently and to the patient's benefit. This requires that the psychologist forward a summary of his diagnostic findings, a summary of psychotherapeutic contacts, and a cover letter ex-

plaining in full the reason for transfer to the one taking the case. This is not only a responsibility to the patient, but a professional courtesy to the new therapist.

It is the patient who usually decides that therapy has been completed. This decision seldom develops during a single session. Often mild, situational resistance occurs during several sessions consecutively, long after resistance has been analyzed. At this point, the therapist must review the case notes and determine if the terminal phase of therapy is approaching. If this is found to be the case, the issue should be discussed openly, and the patient encouraged to discuss his plans.

When the patient finally indicates that he wishes to "try it on his own," the therapist, unless serious indications forbid this, should encourage such a move. The final word should be an invitation to the effect that should the patient ever be in need of further consultation or psychotherapy, "the door is open." Some patients feel insecure about terminating suddenly and request that they see the therapist at less frequent, "tapering off" intervals. This should generally be encouraged. It is at this point that the groundwork is laid for follow-up. It is not unwise for the patient to have a single appointment in three or six months to give him an opportunity to discuss post-therapy progress. This enables the therapist to do some follow-up evaluation.

When a case finally terminates, the therapist should briefly review the entire process and summarize the case in a closing note which then becomes part of the clinical record (Appendix B). At the time of termination, the patient should be informed that the case records are available should they ever be needed, and that the psychologist will forward a summary to any competent professional person upon receipt of the patient's written permission.

## SOCIAL CONTACTS WITH PATIENTS

Most therapists agree that psychotherapy is a frustrating, less-than-successful, or even dangerous process with relatives, friends, and social acquaintances. The therapist's role as an accepting, non-

judging, confidential professional person is seriously impaired by any regular social contacts with his patients. Except for special forms of psychotherapy (children, psychoses, and a few others) the formal psychotherapeutic atmosphere of warmth, acceptance, confidentiality, and objectivity cannot be replaced or approached by companionship.

Research has not as yet described or evaluated the meaningfulness, efficiency, or depth of the successful psychotherapeutic process. It is, indeed, almost impossible to describe. Every therapist and patient who has been exposed to successful psychotherapy is aware, however, that it indicates the flexibility, the capacity, the responsiveness, and the courage of the individual.

# CHAPTER 8

# Special Therapeutic Functions

SERVING IN a community, the psychologist in private practice will have an opportunity to give special therapeutic services in a wide range of situations. As noted in the last chapter, a distinction was made between counseling and psychotherapy. In the present chapter we will discuss a variety of situations where the psychologist may give brief or extensive service in other than the usual therapeutic role. These functions are certainly not new, but the private practice setting is unique in the opportunity it offers for performing varied services often otherwise absent in the average community. The range of such services will vary with the needs of the community.

## GROUP PSYCHOTHERAPY

An area of growing professional interest since World War II (*62*), group psychotherapy has been found to be an effective

method of helping people in distress. One of its primary advantages is said to be the more economical availability of psychotherapy to a larger group of patients in need. Although this is certainly true, it has been found that group psychotherapy is even more effective than individual sessions in particular circumstances. In addition to usual therapeutic groups, some examples of specific opportunities particularly applicable to the community setting will be noted.

### *Groups for Mothers of Disturbed Children*

As indicated in Chapter 4, a large portion of the initial case load in private practice is likely to consist of child behavior problems. In the majority of these cases, evaluation indicates that the parents have a significant role, not only in the etiology of the problem but in its possible remediation. In some instances, one or both of the parents are so disturbed that individual psychotherapy is recommended. More often, however, the parents are willing and *almost able* to follow recommendations that would tend to help the problem. "Almost able" would mean in this case intellectually capable to accept the results and recommendations of the psychologist, but uncomfortable and inconsistent in their ability to follow through. This is particularly true of mothers of disturbed children. The mother usually bears the brunt of the recommendations since she is the parent who spends the greatest amount of time with the child. She not only must deal with the youngster all day, but suffer the admonition, advice, and seldom-helpful attitudes of her husband who comes home after a day away from the problem, mainly wanting some peace and quiet, and perhaps his wife's attention.

We have found that where the mother of a disturbed child accepts a recommendation for group therapy, and participates in this program, the entire family tends to benefit. Not only is her tension and anxiety usually relieved, but she is better able to understand the child's needs. She often learns to understand her relationship with her husband better and thereby becomes able to motivate him to support the therapeutic program.

Groups for mothers generally meet once per week with each

session an hour and a half long. Some mothers benefit after as few as five or six sessions. Others continue for thirty or forty sessions. The group is best held in number from three to seven members. Fewer participants make the situation one of sibling-rivalry with constantly developing resistance, difficult to resolve. More than seven in the group usually leads to the passive members of the group being consistently left out. These groups have been found to be effective with either a male or female therapist as supervisor.

### *Groups for Fathers*

Although this should be important in helping to solve family difficulties, it is almost impossible to form a group for fathers of disturbed children. Although there is the practical problem of the time of meeting, since most fathers are employed during clinic hours, even when evening hours are made available there is a noticeable resistance to group therapy by fathers of disturbed children. Efforts in this direction continue and perhaps new approaches will be found.

### *Adolescent Groups*

The adolescent has been considered one of the most difficult candidates for any kind of psychotherapy. The rebelliousness and resistance to authority encountered in this group makes therapy always difficult, and often impossible. So often the therapist is seen as merely the tool of the restricting and misunderstanding parent. Motivation to leave individual therapy is strong and consistent.

This attitude is also encountered in groups of adolescents. It has been found, however, that where the adolescent has had ten to fifty sessions of individual therapy, no matter how little the observable progress has been, transfer to a group often results not only in participation, but marked progress. In some instances, transfer to a group is the only way the adolescent can overcome the resistances that impede individual therapeutic movement.

We have found that certain conditions seem to make for successful group therapy with adolescents. As was mentioned above, pre-

vious individual psychotherapy is helpful. Ordinarily the adolescent is not responsible for his fee in the individual sessions, but it has been found to be valuable to make financial responsibility, for at least a part of the fee, mandatory for membership in the adolescent group.

The setting is of some importance. Although the adolescent can tolerate an hour and a half of therapy a week, he rarely can do this sitting still. A room which provides a table, a blackboard, and some space for movement is helpful, since sometimes the group wishes to discuss and illustrate their problems and ideas actively and dynamically. Male therapists have been found to be somewhat more effective with these groups.

### *Special Groups*

This area was brought to professional attention by the Officers' Wives Club of a Strategic Air Command Base. The wives of men in hazardous occupations, while maintaining a calm and accepting attitude, are often anxious and fearful concerning their mates' occupation. At first, a group experience was requested for the junior officers' wives. Specifically set at sixteen weekly sessions, the group was so successful that several additional groups were requested for senior officers' wives. Conducted much the same as any group psychotherapy situation, pretherapy and posttherapy evaluation indicated significant gains in insight and acceptance of the self and role for a majority of the participants (*63*).

Such groups find great acceptance and need among the families of men in either hazardous or tense occupations. The mates of policemen, firemen, physicians, and the like need and use group psychotherapy experiences to understand, accept, and enhance their roles.

## CO-ORDINATED THERAPEUTIC PROCEDURES

Although psychotherapy is considered to be an individualistic, confidential, personal technique or relationship, certain situations occur wherein the psychologist is required to share the experience,

or in some cases, co-ordinate the therapeutic course with other situations of importance in the patient's environment. This is particularly true of the limited-type of psychotherapy role played in hospitals where the psychologist is utilized as part of the medical and surgical staff. Some discussion of specific cases seems worthwhile.

### *Counseling and Environmental Manipulation*

In all cases, the treatment of the child must be co-ordinated with the environment within which the youngster functions. Although this may be done through a different therapist who sees the parents, it is often more effective when the child's therapist has regular conferences with the parents or guardians in order that this interrelation may help to bring the therapy and the environment on a closer plane of emotional equality. These conferences particularly help the parents to feel their own importance in the child's program.

Too often the school is completely forgotten as an important part of the child's environment and needs. A large portion of the child's time and emotions are involved in a school setting. Since a child's reactions, positive or negative, are likely to occur in school as well as at home, this setting deserves attention during the therapeutic course. The child's teacher, when it is deemed necessary, should be made aware of the child's emotional needs and the reasons for the therapeutic program. Most teachers are not only willing, but prepared to receive information and suggestions as to how they can help the child adjust satisfactorily.

The private practice setting is one where such liaison can be most effectively carried out. The clinical psychologist, as a professional person in the community, unhampered by agency affiliations and too-frequent red tape, is able to contact and deal with many of the people important in the child's surroundings.

### *Collaborative Psychotherapy*

The clinical psychologist in private practice may be called upon by local physicians and surgeons to conduct psychotherapy with

certain of their patients. The surgeon may have a child or adult who must have an operation under local anaesthesia, but the anxiety of the patient is so extensive as to be a matter of serious concern. An obstetrician may be dealing with a patient who approaches term with an emotional reaction potentially dangerous to mother and child. In these and other medical and surgical situations, the psychologist may be called upon either for recommendations or brief, intensive psychotherapy with the patient.

The medical regime and environmental program necessary for patients following cardiovascular disease are often irritating and restricting. Where conflict is severe, or the patient's emotional reaction is not in keeping with a program of recovery, the cardiac specialist may call in the psychologist to help the patient accept and adjust to the new program through brief, intensive therapeutic contacts. Once the medical specialists in a community are aware of the practicing psychologist's training and ability, they are willing to collaborate in appropriate cases. This type of work has been reviewed recently (*64*).

### *Multiple Treatment Program*

The psychologist may conduct psychotherapy with individuals who are receiving regular attention from other professional people, in some relation to the patient's total problem. For example, a patient may be receiving psychotherapy and speech therapy at the same time. Where these treatments occur in the same setting, staff conferences facilitate communication, but in the private practice setting, the various treatments may occur in vastly different physical and professional settings. Unless some provision for professional liaison has been accomplished the psychologist should probably make efforts to set up meetings or conferences where the entire program may be understood and planned by the professional people involved. This is not only an effective measure for establishing good interprofessional liaison, but is necessary for the accomplishment of the maximum treatment benefits for the patient.

*Program Consultation*

After the clinical psychologist evaluates a patient, he may, through choice or necessity, turn over the treatment or counseling program to another professional person or agency. In the case of Juvenile Court referrals, the psychological evaluation report helps determine the court's disposition of the case. Often the youngster is assigned to a probation officer, social worker, or juvenile counselor. In the private practice setting, the psychologist will often be called upon to counsel and advise these professional people in their therapeutic work with the patient. Based on his general knowledge of human behavior and therapeutic processes, as well as his specific diagnostic knowledge of the patient, the psychologist is in a reasonable position to play this counseling-consultative role.

# Part III

# PROFESSIONAL LIAISON AND RESPONSIBILITY

# CHAPTER 9

# Professional Relationships

THERE IS general agreement in the profession that the psychologist should not practice in complete isolation. Various suggestions are made as to the type and frequency of professional contact necessary for adequate practice.

## OTHER PSYCHOLOGISTS

In starting practice, the clinical psychologist must, unfortunately, face the fact that he will often find the least acceptance of his role in the community among his own colleagues. Unless the professional psychologists of the city have had experience with capable clinicians in private practice, the "burden of proof" will tend to be on the new man. Outright hostility will seldom be encountered, but the implications of such will be seen in a lack of enthusiasm and encouragement offered by colleagues.

Psychology has won status as a research and institutional profession. Private clinical work is a relatively new application, and

psychology as a profession will be judged to some extent by the practitioners who come in contact with the general public. The answer to the attitudes of colleagues is the performance of the private practitioner. Responsible, conscientious practice with a full awareness of limitations is the surest road to acceptance.

Participation in local and state psychological association functions is not only a desirable goal for all psychologists, but particularly so for those in private practice. Not only is this helpful for professional growth and development, but provides an opportunity to communicate with other practitioners. Some clinicians in private practice feel that psychological associations are "university dominated" and that the papers presented at professional meetings are "dry stuff . . . experimental, etc." Such an attitude is self-defeating. Professional competence can only be obtained and maintained by continual awareness of the broad and changing nature of psychology. Not keeping up with research developments may lead to less-than-adequate services.

## PSYCHIATRISTS

A conversation between psychiatrists more than occasionally begins or ends with "Yes. . . . I know some fine clinical psychologists, but too many of them are . . .," followed by more or less negative comments. Now let us examine the other side of the coin. Most clinical psychologists take a rather defensive, frightened, or evasive attitude toward psychiatrists at one time or another. Like the psychiatrist, most psychologists can say, "but Dr . . ., he's different."

Most psychologists and psychiatrists are reasonable human beings. The reason for the defensiveness has been discussed pro and con (*65*, *66*, *67*). So often the psychiatrist we like best is the one we know best. This seems elementary but it is infrequently applied by too many psychologists. For the clinician in private practice, getting to know the psychiatrists he is to deal with is a necessary requisite to successful practice. Being a member of the younger

field of private practice (as well as being well-trained in human relationships), it is the psychologist's role to initiate and effect liaison.

It is often to the patient's benefit that psychiatrists and psychologists practice collaboratively. There is conflicting opinion as to where the fields overlap. In the area of diagnosis, the psychologist is in an excellent position to make detailed objective as well as clinical observations about intelligence, interpersonal capacity, achievement, and social adjustment. Psychiatrists are becoming more aware of the separate and valuable place of clinical psychology in dealing with emotional disturbance. The clinical psychologist's extensive basic training in developmental processes, social processes, and learning behavior is invaluable in the complete evaluation of individuals with interpersonal difficulties.

In the area of psychotherapy a greater degree of misunderstanding exists. If therapy is considered a learning process, the psychologist is seen as practicing an appropriate role. When psychotherapy is described as a medical role, the psychologist is seen in a different light. The fact remains that clinical psychologists are well trained in psychotherapeutic functions and have been practicing as well as doing research in this art for many years. In the private practice setting, the clinical psychologist will have an opportunity to examine a wide variety of emotional disorders. In the selection of patients for psychotherapy, the psychologist will find ample opportunity for close and frequent collaboration with psychiatrists. There are many cases the psychologist may not feel equipped to handle, depending on the background and experience of the particular clinician. Just as many psychiatrists do not work with marital difficulties, child behavior problems, and cases of poor vocational adjustment, many psychologists will prefer to have schizophrenia, impulse neuroses, or other conditions handled by a psychiatrist.

Where the diagnostic evaluation indicates that hospitalization is required, referral to a psychiatrist is warranted. Unless the psychologist has an appointment on the visiting staff of a hospital equipped

to handle acutely disturbed patients, the patient will be best served by going through the entire treatment process with a psychiatrist who has access to appropriate facilities.

When the psychologist takes a case which is likely to involve severe depression, acting-out behavior, or psychotic episodes, psychiatric consultation and collaboration during the diagnostic and treatment process is indicated. In some cases it is advantageous for the patient to receive psychotherapeutic attention from one source and medical treatment from another.

Where the diagnosis reveals the possibility of intracranial pathology, the psychiatrist is the best-equipped person to evaluate the entire social-psychological-physical situation in order to determine the contribution of each factor to the patient's condition.

Although psychiatrists can practice diagnosis and treatment of emotional disturbances in a less-than-complete way without psychologists, the practicing psychologist's services will be severely limited without an effective association with psychiatrists. These productive interprofessional contacts frequently exist and there is no reason to believe that differences between the two professions cannot be eventually resolved by closer communication and continued effort.

## THE MEDICAL PROFESSION

Medical practitioners as a group are fairly unfamiliar with psychology, much less clinical psychology. In some instances, the psychologist is seen in much the same light as the chiropractor, and naturopath; intruders in the medical arts. At the other extreme, some physicians consider the clinical psychologist specifically as a psychoanalyst, trained in Vienna and capable of handling all sorts of "strange neurotics."

In working with the medical personnel of the community, it is the psychologist's responsibility to take upon himself the long range job of educating these professional men as to the nature and functions of clinical psychology. A friendly and open attitude is helpful

but can only facilitate adequate clinical work for winning professional acceptance.

Initial contact with physicians is sometimes made when the psychologist refers a patient for physical examination. The family physician is often interested in the findings of the psychologist, and indeed can be of great help in encouraging the patient to follow a psychotherapeutic program. Pediatricians have been found particularly helpful, in this respect, where children are involved. The diagnostic report sent to the referring physician is a valuable educational measure.

As the psychologist becomes an integrated member of the professional community, he will find that medical men not only tend to accept him as a person of competence in a specialized field, but show an interest and awareness of the community's needs for psychological services. Psychologists should encourage the medical as well as other professions to inquire further, attend occasional psychological meetings of interest, and to participate in interprofessional affairs.

The practicing psychologist has a responsibility to his patients to utilize appropriate medical referral and collaboration. During the diagnostic process it is essential that physical conditions be ruled out as etiological aspects of the problem under consideration.

When dealing with children, the psychologist must pay particular attention to the clinical history and the consultant physician's report, since much unusual behavior in children *can* be based on physical disorders. The psychologist must avoid situations where he treats restlessness, irritability, poor attention span, and lowered school grades with play therapy, when the child is reacting to pinworm infestation, or endocrinological imbalance.

During psychotherapy, anxiety is often exhibited by way of a psychosomatic defense. Hypochondriacal conditions exist or arise in diagnosis and psychotherapy. Immediate referral to a physician for evaluation of the physical situation is an unquestionable responsibility of the psychologist in charge of the case.

At times the psychologist will be asked to begin therapy with a

patient whose primary symptom is a psychosomatic disturbance. Migraine headache, hypertension, ulcer, asthma, and other diseases are included in this group. Again, the psychologist must insist on continual observation by a physician of the patient's choice.

## COMMUNITY AGENCIES AND FACILITIES

Unless the psychologist works as a technical assistant in a psychiatrist's office, a knowledge of, and working relationship with, community agencies is essential. The clinical psychologist often will deal with cases which require foster-home placement, specialized treatment, rehabilitation, and other agency services.

Most large cities have Family Service associations, Guidance Centers, Child Welfare departments, and other facilities. These agencies may be used in several ways. Information that might be helpful in diagnosis or treatment can be obtained if the client has been seen at these agencies. Following the diagnostic procedure, the client will often benefit from planning and procedures which can be carried out only by agencies with specialized facilities. These agencies are usually willing to support and follow programs recommended by the clinical psychologist. Referral of patients often results in the agency making return referrals and requests for service, thus encouraging a closer professional relationship.

The following agencies are to be found in most metropolitan areas:

### *Family Service Associations*

These organizations are frequently staffed by well-trained psychiatric social workers and social case workers. They sometimes have psychological and psychiatric consultants. Foster-home problems can be best handled by referral to this type of agency. Family Service can be helpful in home-planning problems, ranging from homemaker services while the mother is in the hospital or receiving psychotherapy to the budgetary and administrative planning necessary where a home setting is thoroughly disorganized.

Marriage and family counseling are usually available. Each association offers different services and will have to be visited by the psychologist who wishes to make referrals.

*Child Welfare Department*

Sponsored by the state, county, city, or all three, communities ordinarily have such an agency which provides specialized social service for family problems. Where action is necessary to stabilize home situations over a long period of time, this agency is often of great help in effecting the recommendations resulting from psychological evaluation.

*Legal Aid Society*

On occasion, legal advice becomes a necessary part of an over-all emotional problem. Although the clinician may recommend consultation with an attorney, the patient may not have a regular legal counselor. Most Bar Associations support a Legal Aid Society to which an individual professional person or agency may refer for initial legal counsel. Attorneys serve the society on a rotation basis and offer suggestions and advice concerning legal difficulties. After the initial contact, the attorney representing the Legal Aid Society will recommend a lawyer who can be of help with the particular problem.

*Child Guidance or Mental Health Clinic*

Although these centers offer services similar to those of the clinician in private practice, they can be utilized as a consultation center for re-evaluation of clients. In cases where more than one family member must be treated, these agencies may be able to provide the therapists to accomplish the program. When the clinician in private practice is not prepared to deal with child problems, these agencies are excellent referral possibilities.

*Alcoholic Rehabilitation Clinics*

Many states have developed programs specifically for the diagnosis, treatment, and rehabilitation of alcoholics. The psy-

chiatrists, social workers, psychologists, and physicians who staff these centers are specifically trained and experienced in dealing with this unique emotional disturbance. In addition to local outpatient treatment centers, the state often supports one or more treatment centers for in-patient help, where required. These professional workers are often successful with alcoholics where the Alcoholics Anonymous program has not produced lasting effects.

### *State, County, and City Health Departments*

Referral to public health agencies for physical problems is sometimes necessary, where referral of patients to a private physician is impractical. In addition, the local health department is an excellent source of information concerning state hospitals, treatment facilities for narcotic addicts, and other specialized programs.

### *Vocational Rehabilitation Agencies*

Such agencies are provided for the vocational rehabilitation of city or state residents who are recovering from mental or physical handicaps, and who are in need of training and guidance in job placement. This type of agency is an excellent source of aid in the final steps of appropriate treatment programs. In some cases, it is helpful to co-ordinate the psychologist's program with the agency's facilities throughout the treatment plan. This agency sometimes handles or co-ordinates activities of agencies for the blind, deaf, The Crippled Children's Commissions and other specialized treatment and rehabilitation agencies.

### *Departments of Special Education*

Facilities for special education are provided by most states at the local level. When working with children, the psychologist will find that such an agency can provide opportunities for a broader and more effective treatment program for certain children. Arrangements can be made so that the child's school setting facilitates the recommended treatment plan. Counselors and teachers with special training make available a broader concept of rehabilitation of disturbed and exceptional children.

### *State, County, and Municipal Hospitals*

Services in these institutions vary considerably from state to state. The psychologist in private practice will often meet problems of such serious nature as to require immediate institutional care. It would be well for the practicing clinician to be fully aware of the hospital facilities, means of referral, and services offered by his community.

### *Private Schools and Nurseries*

Every major city has a variety of special, private educational settings for children and adults. The range of adequacy in such facilities can be considerable. The psychologist will do well to spend some time familiarizing himself with these settings, so that he can make meaningful recommendations and referrals should the occasion arise.

These are only a few of the facilities available for referral. Each community differs and when beginning practice, the psychologist should investigate the services his community offers. If facilities are minimal, there may come a time when the psychologist may be helpful in recommending such services be established (see Chapter 11).

Appendix A contains a list of the names and addresses of agencies which provide referral opportunities. The directories of such agencies give the clinical psychologist in private practice a valuable reference library of ancillary, consultative, and referral services.

# CHAPTER 10

# Institutional Affiliation

AS THE CLINICAL PSYCHOLOGIST develops his private practice and becomes known in the community, it is likely that he will have opportunities to affiliate himself with various institutions or groups. Some of the opportunities will be of undoubted value, while others can be detrimental. Care in the choice of affiliation is of the utmost importance.

Affiliation with established institutions may offer many advantages. In some cases the benefit is monetary. This is rarely a primary consideration, as the rate-of-pay for psychological consultants in a community is usually much less than income from office practice. Primarily, such affiliation provides an opportunity for the clinician in private practice to function in a variety of stimulating professional situations, helping to enhance and maintain competence and perspective. Clinical psychology is a dynamic and ever-changing field and the absence of discussion, interaction, and education at the professional level retards professional development.

Caution should be observed regarding the choice of affiliation.

Some institutions would like to have a qualified or well-known psychologist as a consultant in order to enhance their program, without really availing themselves of the services of the psychologist. To lend one's name to an institution of this type may invite embarrassing or even professionally disasterous results. An example of this occurred recently:

A psychologist of some note and importance in the state, Dr. X, consented to affiliation with a group for advancement of education and its principals. He lent his name for "prestige" and actually served in no professional way with the group. At the yearly state meeting of this group, the keynote speaker, following an introduction by the governor of the state, turned out to be a well-known charlatan who gave ridiculous lectures on mental health, billing himself as "one of the nation's foremost psychologists." This was discovered by the committee on standards and ethics of the state psychological association, and the facts became known to the executive council and a large proportion of the members of the association. Investigation indicated that the charlatan had been hired, at a substantial fee, by the program chairman, through a lecture bureau. The local psychologist had never been consulted, or informed. Much criticism and recrimination was directed at Dr. X for being involved in the executive committee of the group and not knowing what was being done by the group that used his name.

The responsibility in such situations clearly rests with the individual psychologist who accepts such an association. Once an affiliation is accepted, it is the individual's responsibility to serve his role adequately by taking part in the functions of the institution or affiliation. The nature and extent of the participation should be clearly understood by all parties. To wit:

A psychologist in private practice was asked to serve as the chairman of research in a municipal Co-ordinating Council, made up of leading citizens who felt that the many agencies and services of the community could be integrated and enhanced by the efforts of such a council. The psychologist was very lax about attending the monthly meetings, and during the time he was absent, the council proceeded with a "research project" in which they compared one mental health agency with another in the community, much to the detriment of one of the two. Their report was printed and widely distributed. The study was little

more than a collection of vague observations to support a rather biased and vindictive opinion toward the maligned agency. Much lay and professional criticism ensued, including a scathing attack on the council itself, in private meeting, by their negligent director of research. When the smoke had cleared, the blame for the unfortunate circumstances was laid at our psychologist friend's feet. The Council's reasoning was that it was his place to be present and guide their research efforts before they got into difficulty, rather than being critical after the fact.

When affiliation is accepted, whether honorary or paid, the psychologist is duty bound to treat his responsibilities with the same interest and application as he would in direct clinical practice. If this is not possible, affiliation should be refused.

## THE MUNICIPAL HOSPITAL

Although in our largest cities psychologists are employed on the staff of the municipal or general hospital, they are too often selected as technicians who service the psychiatric section. Only recently have psychologists in clinical practice began to affiliate with hospitals as members of the visiting staff. In some communities such an appointment is willingly granted to qualified psychologists, while in other communities, such visiting appointments are refused by the medical staff.

An appointment to the visiting staff of a municipal hospital is undoubtedly a valuable affiliation for clinical psychologists in private practice. It establishes a close rapport and source of referral with psychiatrists and other physicians in the community. With such an appointment, the psychologist is in a position to directly refer seriously disturbed patients for acute psychiatric in-patient treatment. Furthermore, the visiting appointment enables the psychologist to continue seeing patients during intensive treatment programs and, indeed, participate in such programs. With the appointment, the patient can be followed after hospitalization without several complicated changes of responsibility between the psychologist and the psychiatrist who must handle the case entirely if no staff privileges are available to the psychologist.

How are such appointments obtained? Primarily it depends on the interpersonal climate in the psychological-psychiatric-medical community. If even one influential psychiatrist opposes either the general idea of visiting appointments for psychologists or appointment of the particular psychologist making application, it is most unlikely that any affiliation will be established. It is simplest where other psychologists have received hospital appointments and have more or less set some precedent for this affiliation.

Where the clinical psychologist in private practice sets out to obtain the first visiting staff affiliation for a psychologist, he has his work cut out for him. The first prerequisite, of course, is that the man be clearly qualified to work in the hospital setting as an independent and competent professional psychologist. To achieve this one doesn't merely present a set of credentials to illustrate one's qualifications to the hospital's medical staff. A long and involved process of becoming well-known and respected by the psychiatrists and other medical men of the community is the only way to establish a reputation for competency.

At such time as the psychologist has become well-known and accepted by the medical profession, it is helpful for him to offer his psychological skills "on service." Some gratis working time should be offered, generally through a senior staff psychiatrist, to the out-patient or in-patient treatment facility (generally neuropsychiatric but sometimes pediatric) which is most in need of such services for the charity patients of the city. This is only proper, since every physician serves in this way for the privilege of being a member of the hospital's visiting staff.

After the psychologist has worked "on service" for some period of time, and assuming that his performance has been satisfactory, he should then discuss the question of appointment with the staff psychiatrist with whom he is most closely associated. It is generally *not* a wise idea to make a formal application to the Board of Governors or the Chairman of the Medical Staff without laying informal, personal groundwork. Such a direct application without precedent is likely to be rejected.

If the psychiatrist with whom the subject is discussed feels that such an appointment might meet with approval, the matter should be taken up, again informally, with the chief of the neuropsychiatric section of the hospital. If all goes well at this point, the "friendly" psychiatrist and the chief of the neuropsychiatric section will probably sound out their colleagues, and perhaps arrange for the psychologist to meet key members of the medical staff who are not familiar with the psychologist and his work. Sometimes the psychologist is asked to participate in a clinical meeting where a case in which he has collaborated is taken up so that the medical staff may actually see how and why a clinical psychologist serves a role in the hospital setting. Occasionally the psychologist is invited to address the local medical society, not infrequently on the suggested topic "The Relation of Psychology to the Medical Arts." All these preliminaries are designed to acquaint the staff of the hospital with the psychologist and his functions so that they can make an informal evaluation of the man and his work before the time comes to vote on his application for affiliation.

If, after all this, the psychologist is finally asked to submit an application for appointment to the visiting staff, the chances are strongly in his favor that the appointment will be granted. If any great resistance to his appointment has developed, he will usually be told of this, informally, by one or both of the psychiatrists through whom he began the application procedure. In such cases, the psychologist will not be invited to make formal application. If the application is rejected, it is generally wise to accept this rejection in good grace, and work with close associates and friends in the medical profession toward eventually overcoming the objections to psychologists being appointed to the hospital staff.

## PRIVATE HOSPITALS

Many cosmopolitan areas support private hospitals which are either partially or entirely devoted to the care of neuropsychiatric patients. Some of these institutions have staff psychologists who

work full or part-time with the regular medical staff. It is often possible to obtain an appointment or consultantship to such hospitals. Duties may be supervision of psychologists who are staff members, or the offering of limited psychological services, usually diagnostic, on a regular part-time or "on call" basis. Such affiliations are desirable particularly where the institution offers the advantage of continual clinical experience and professional stimulation.

Appointments to private institutions are usually obtained through some professional person, usually a psychiatrist, who is rather influential with the hospital staff. Here again, the most direct route to such an appointment is to become known as a competent and dependable clinical psychologist.

## CONSULTATIONSHIPS

Aside from affiliation with medical institutions, most communities support agencies and facilities which are in need of part-time psychological services, or psychological consultation. In some of these settings the need for psychological service is infrequent, but nonetheless occasionally necessary. Here again the psychologist may obtain an appointment which is both financially and professionally helpful to him. Some of these situations (which will vary from city to city) are indicated below:

### *The Children's Home*

Many communities support an organization which cares for orphans and deserted children. Children at these homes are placed for adoption, and psychological evaluation is often required. Recently some of these institutions have extended their investigation of prospective parents by requesting psychological evaluation of the couple applying for a child. While few of these homes employ a staff psychologist, they are often able to employ a part-time consultant.

### *The Juvenile Court*

Metropolitan areas generally employ staff psychologists in the Juvenile Court. Many smaller communities have rather active juvenile courts, staffed with counselors, probation officers, and social workers. Few employ staff psychologists, yet the services of a clinical psychologist are frequently in demand. Psychological evaluation is particularly helpful in pre-sentence investigation, offering information about the youngster that will guide the judge not only in his legal decision, but in the recommending of a rehabilitation or parole program.

### *Private Schools*

Educational facilities, particularly those specializing in exceptional children, utilize professional people in the community as consultants not only in the evaluation of individual problems, but also to help establish policy, methods, and procedures for particular educational programs. A psychologist may be consulted to make recommendations in these areas.

### *Family Service Associations*

One of the many nationally-sponsored community agencies, this organization offers a variety of social service benefits to the community, including marriage counseling, care of unwed mothers, counseling parents of children with developmental problems, social adjustment for the aged, and other welfare problems. A clinical psychologist in private practice may make his professional skills available, on call or through regular consultation, to aid in some of these services. Differential diagnosis and recommendations for disposal or referral of the case are the most frequent services desired.

Cities vary in the community institutions and services available. As the psychologist establishes his practice, learns about his community, and in turn becomes known by the community, opportunity for professional affiliation will become apparent and available.

# CHAPTER 11

# Ethical Standards

ETHICAL STANDARDS refer to the rules, regulations, attitudes, and inhibitions which govern the behavior of a particular individual in his professional role. In 1953 the Council of Representatives of the American Psychological Association, after long and intensive work, published a 171 page volume entitled *Ethical Standards of Psychologists* (*32*). This work was the *preliminary* basis of ethical standards agreed upon by the Executive Council of the American Psychological Association. The plan in force at the present time is for these rules and regulations of conduct in the profession to be tried by psychologists, and later revisions of the code formulated on the basis of experience. The amount of work and interest in the area of ethical standards indicates its importance in the field of psychology.

Professionally, the physician has the oldest and most consistent code of ethics, primarily based upon the Hippocratic Oath. No such simple dogma exists for the psychologist.

This chapter deals specifically with the aspects of ethical behavior that apply to the clinical psychologist in private practice.

## INDIVIDUAL RESPONSIBILITY

Responsibilities for one's patients, an area which has received very little attention in the field of psychology, is the most important ethical consideration in the private practice of clinical psychology. Most clinical psychologists have had experiences where they were told that a physician must always have ultimate responsibility for a case. This is found more frequently in institutional and agency settings. In private practice, no such direct responsibility is feasible unless the psychologist practices with and directly under the supervision of a psychiatrist. Such practice is not private practice, indeed, but a special form of assistantship. Most psychologists disagree with the attitude that any psychologist who does psychotherapy or even diagnostic testing should be supervised by a physician, "preferably a psychiatrist." Although we as clinical psychologists resist such a dictum rather strongly, we have presented no substitute in terms of our willingness to accept responsibility. If clinical psychologists are capable professional individuals, they must be prepared to take responsibility for the work they do, and in certain specific instances for the people they work with. Such an opportunity exists in the private practice setting.

## SELECTION OF CASES

The psychologist's capacity to take individual responsibility for patients begins with his selection of patients. The patient will approach the psychologist for service, but before service is given, a short or long period of "selection" must take place. The psychologist must, on the basis of his own judgment, decide how appropriate his services may be in relation to the problem of the

patient. In the broader point of view, the clinical psychologist is aware that he cannot accept a patient, basically suffering from a tumor of the brain, who is anxious and tense. It is fully clear that this is a medical problem. On the other hand, the psychologist can be perfectly willing to accept or "select" a case in which he must determine the intelligence level of a normal adult. Between these two extremes there are very many situations where good judgment and a full awareness of one's own capabilities and limitations are the only guideposts for the selection or rejection of a patient.

There are no specific rules and regulations for accepting cases. Certain general criteria, however, might be applied in determining the appropriateness of psychological services for a specific situation. The following arbitrary recommendations are made:

### *The Need for Service*

In selecting a case the psychologist should be able to determine whether or not the patient is in actual need of service. In situations where it is doubtful that the patient is requesting psychological services, under no circumstance would it be considered ethical for the psychologist to "convince" the prospective patient that psychological services would be appropriate and helpful. Where the patient is in doubt as to whether psychological services are required, it is generally best to allow the patient to consider this in terms of his own judgment and without undue pressure from the psychologist. Coaxing of patients seldom, if ever, proves worthwhile, either for the psychologist or for the patient.

### *Appropriateness of the Problem*

When a person seeks the services of a clinical psychologist in private practice, in all cases, during the intake procedure the psychologist must decide how appropriate psychological services are likely to be in dealing with the patient's problem. Where there is any question whatsoever, the patient should be informed in a direct manner that the procedures which are to be instituted will be of

an evaluative or diagnostic nature, with no guarantees that the services rendered will be specifically applicable to the patient's problem.

*The Patient's Awareness of Community Resources*

Whereas the medical profession definitely distinguishes between private and charity service in most municipalities, a great variety of psychological services are usually available in major cities other than in the "charity ward." Guidance centers, school psychologists, psychologists attached to businesses or industries, and other agency and institution personnel often have psychological services which may be available to the general public. The patient should always be made aware of such services before psychologists accept the case. To give an example, should a college student, anxious for vocational guidance, approach a private psychologist requesting such service, if this student's university offers such services, the psychologist is ethically bound to so inform his client. Usually the patient is well aware that such services are available, but prefers to deal with a private professional person.

*The Psychologist's Awareness of His Own Ability*

As noted in Chapter 4, a considerable variety of problems and patients will come to the clinical psychologist in private practice. In many instances psychological services are necessary, and the individual psychologist is well trained and qualified to deal with these problems. In certain situations there will be a question as to whether the psychologist has had the specific training or background to deal with the patient. In any case where there is the slightest doubt of the psychologist's background in relation to the patient and his needs, the psychologist is ethically bound to refer the patient to a more competent professional person.

*The Psychologist Must Reasonably Expect to Carry Out a Program*

This applies to a number of different situations. Where the clinical psychologist is in part-time private practice, a patient may be

examined and found to be in need of long-term psychotherapy. A psychologist who is in private practice part-time and not likely to remain in the community is ethically bound to refer the patient to a therapist who is likely to be able to carry through long-range therapeutic programs.

The question of multiple services should be considered in planning a program for a patient. If the patient requires a variety of services, for example, speech therapy, physical medicine, and psychotherapy, and the psychologist is not prepared to co-ordinate a program of multiple services, referral to a facility, if available, that is capable of offering the entire group of services should be made.

### *Conscientious Referral*

Clinical psychologists are in agreement that whenever they deal with emotional problems there is always a possibility that physical and environmental factors may influence the situation beyond the emotional factors involved. Every patient should receive a complete physical examination before beginning psychotherapy, or before completing a full diagnostic evaluation. Too often the clinical psychologist will accept the patient's statement, "Oh yes, I had a complete physical last month." Too often it is found that the patient's statement, if questioned carefully, refers to a brief medical consultation for a transient condition. The psychologist should be certain that a competent and well-qualified physician has made a thorough examination of the patient. In order to determine this, a report from the examining physician should be requested. An example of the necessity for this follows:

A patient, an apparently healthy man of approximately thirty years of age, superior intelligence, and of good socioeconomic standing, applied for a psychological evaluation because of a recent and moderately intense attack of anxiety which he related to job dissatisfaction. The man held an executive position in an industrial manufacturing company and he indicated that for a period of several months he "just couldn't get started."

As a result of the psychological evaluation, the psychologist felt there may have been factors of intracranial pathology operating. The patient indicated that he had a complete physical examination approximately

six months previously to his psychological consultation. This report was negative, but the clinical psychologist felt that a more immediate and more thorough physical examination was required. The patient became rather indignant about this, and insisted that the psychologist offer him a course of psychotherapy to resolve the anxiety. The psychologist refused, and the patient in turn consulted with another therapist, going through pretty much the same process that he had with the former clinical psychologist. The new therapist requested the psychologist's reports, which were forwarded with a statement as to why the patient had been refused service. This therapist was willing to accept the patient's statement and the physician's report of negative physical examination. Psychotherapy was begun. Three months following the beginning of the psychotherapy, the patient died of a malignant brain tumor.

## RELATIONS WITH OTHER PROFESSIONAL PEOPLE

Often in the course of clinical practice it is necessary to make a referral to a psychologist, psychiatrist, general physician, or other professional person. It is necessary to forward a report of psychological findings to these professional people. Too often we feel that the patient would be more than happy to have us do this, and we may forward such reports without the patient's permission. In all cases where reports are to be forwarded, where the initial contact has been made by the patient himself or the patient's family, specific written permission to forward the report must be obtained. Embarrassment or even harm to one's professional standing can result if this rule is not followed. For example:

A patient was referred to a local clinical psychologist in private practice by a general practitioner. The physician making the referral indicated that this woman had been making a number of complaints about her marriage and her ability to deal with the tensions of everyday life. The physician suggested that the woman see a psychologist or a psychiatrist, and the woman selected the psychologist. Initial evaluation indicated that the woman was moderately disturbed. Psychotherapy was recommended and the woman accepted this. As a matter of courtesy, but without the woman's permission, the psychologist,

at the physician's request, forwarded a complete report of his examination. Shortly thereafter the woman appeared for her therapeutic hour, indignantly asking why the psychologist felt she was this, that, and the other thing. It seems that the report, although sent in a confidential enevelope to the physician, was opened by his nurse and handed to the patient on the occasion of the patient's next visit to the physician. Since the woman had not given permission for this report to be sent, she chose this incident as a route of resistance and terminated therapy. Although she threatened a law suit she never carried this through. Being a rather verbal and sociable individual, she spread a good many stories concerning the psychologist with whom she had the bad experience. Such behavior certainly could not be considered provident to continued successful private practice.

It is rare indeed to find a professional person who does not discuss his cases with colleagues. Such behavior, except in the strictest professional setting, is to be considered unethical. It is true that many of the people we see are unusual and occasionally comic, yet every psychologist in private practice should realize that his responsibility is great. A clinical psychologist in private practice is a member of the community, and inadvertent comments concerning his patients may well be eventually harmful to someone. We all agree that confidentiality must be an integral part of the work we do with people. If we are not prepared to follow through with a realistic guarantee of confidentiality, we should not be practicing in this profession. It often takes a good deal of tact and judgment to avoid discussing a clinical case with a colleague who specifically asks about a certain patient. Such tact should be developed however and practiced in the best interests of the patient.

## CONFIDENTIALITY AND PRIVILEGED COMMUNICATION

Ordinarily we guarantee our patients confidentiality in our contacts. Several articles have appeared however to justify the revelation of clinical material at court proceedings (*68*). Most of these articles have been in the form of apologies for having revealed clinical material. If we do not believe in privileged com-

munication and confidentiality as part of our professional work, we should eliminate these as part of our self-representation. If we are willing to guarantee the patient such confidentiality, it must be carried through. Should a patient's behavior carry him into legal difficulties, and the psychologist should be required to give testimony, the patient's permission should be obtained. Unless the patient is incompetent when such permission is refused, the psychologist is ethically bound to maintain the confidentiality. If this means that the psychologist will be cited for contempt of court, he must accept such a risk. If this is deemed an unreasonable risk, psychologists should make every effort to pass legislation providing the clinical psychologist with privileged communication. If such laws do not exist, the psychologist has but two choices: he may practice his profession with a willingness to take the risk of citation for contempt of court, or he should cease practice.

## THE PSYCHOLOGIST'S CASE LOAD

This has never been considered directly in the published literature. Those clinical psychologists who have practiced in intensive private settings know that the type of work they do and the intensity of this materially influences the quality of professional work. It is doubtful that a clinical psychologist doing sixty hours of psychotherapy a week will continue to be an effective therapist for all of his patients at all times. Psychotherapy is an intense and strenuous experience for the therapist as well as the patient. The psychologist who is overloaded in the number of therapy hours he conducts is cheating some of his patients.

It has been found that a variety of clinical work enables the psychologist to bring to bear his fullest attention and professional skills for the benefit of the patient. For this reason it is wise to space psychotherapeutic contacts with other work in order to "break up" the pattern of continual psychotherapy. Empirical observation among a number of psychologists in private practice over a five-year period indicates that a long but satisfying work

week generally includes approximately thirty hours of psychotherapy, ten hours of diagnostic functions, five hours of conferences and information sessions, and five hours of administrative responsibilities, staff meetings, and other professional contacts.

It is probable that those psychologists who maintain an adequate emotional balance and life adjustment themselves are able to do the best service for patients. For this reason, clinical psychologists in private practice should be reasonable in setting their working schedules. Hard work will be more a necessity than choice, since the psychologist who is successful in community practice will be called upon to spend many more hours in his work than the average agency psychologist. This can be handled in various ways so as to give the psychologist an opportunity to gain his own living experiences and satisfactions in order to be in a better emotional state for the offering of his professional services. It is doubtful whether psychologists in private practice should work evenings as a regular habit. Week-end work is a doubtful procedure also. Many patients prefer evening hours, or in some cases find it necessary to have consultations in the evening. For this reason it may be a wise policy to set aside one day in which appointments are made between 1 P.M. and 9 P.M., thus giving the psychologist a half-day off, and providing the patients with an opportunity for evening hours. This problem of the work week is of course a highly individual matter. Good judgment and careful thought should go into this matter.

## LICENSING AND CERTIFICATION

At the time of this writing, fifteen states have passed legislation for certification or licensing of psychologists. In these states it is necessary for the psychologist in private practice to obtain a certificate or license before he can offer his services for a fee. In those states where no such licensing procedure exists, it would be a wise policy for clinical psychologists in private practice to actively participate in efforts to obtain such licensing.

Before engaging in private practice most psychologists will find that the city in which they practice requires an occupational license. The fee for such a license may vary anywhere between $10 and $100 a year. It is necessary for such a license to be taken out if the psychologist wishes to avoid minor but troublesome difficulties with the local government. In addition to city requirements, county as well as state occupational licenses may be necessary. In many states where there is no specific legislation for the practice of psychology, an occupational license will not be issued under the title *psychologist*. Most of the clinical psychologists who practice there are forced to apply for an occupational license under the heading *educational specialist*, *personal counselor*, or *educational psychologist*. Such a subterfuge may be necessary but it points to a pertinent reason for active support of a program to effect licensure or certification at the state level. The situation of local occupational licensing should be carefully investigated before starting private practice.

## MALPRACTICE INSURANCE

Through the American Psychological Association, a special committee has succeeded in making malpractice insurance available to psychologists. This type of insurance is similar to that held by many members of the medical profession. The Smith-Hogate-Dawson Insurance Agency of Champaign, Illinois underwrites psychologists' insurance, with the annual cost based on the extent of liability coverage. Information concerning this liability insurance can be obtained by writing directly to The Smith-Hogate-Dawson Agency.

Such insurance is a wise prerequisite to the private practice of psychology. There is some argument that malpractice insurance is an invitation to suit, but this is a rather ridiculous argument. Psychologists would no more take out malpractice insurance expecting to be sued than they would take out fire insurance expecting

their homes to burn down. It is a reasonable precaution for operation as a professional.

The clinical psychologist should also take out a policy of personal liability insurance. This has little to do with his practice as a clinical psychologist, but merely applies to the fact that he is operating a business for profit in the community. Should a patient be injured in the offices of a psychologist, the psychologist is liable for suit for medical and personal damages. This is true of every citizen who owns property, or maintains a business of any sort. Personal liability insurance is a wise professional as well as business investment. These policies are available locally. This can be considered as an ethical measure, since by taking out such insurance, the psychologist is able to provide immediate or long-range medical and compensatory benefits for his patients should they be injured within the premises of his offices.

## ADVERTISING

In Chapter 3 some comment was made concerning the kind of professional card and newspaper announcement which may be used to announce the opening of offices. Aside from these initial announcements, as well as a telephone directory listing, no advertising is ethical for the clinical psychologist.

Often the opportunity for "hidden" advertising is available to psychologists in private practice. Civic organizations often request that the psychologist present lectures or speeches to their groups. Certainly the psychologist is entitled to present himself before such groups insofar as his background and training are concerned. But the solicitation of clients during these speeches is an unethical procedure.

The field of psychology is an interesting one. Psychologists in private practice may be interviewed by a reporter from the local newspaper on specific topics, or for a special feature concerning the private practice of psychology. This is usually a very flatter-

ing occurrence, and hard to refuse. It definitely should not be refused under certain circumstances. Every clinical psychologist in private practice is a representative of his profession, entitled to inform and educate the public of the functions of psychologists. Newspaper people have in mind the interest value of their articles and not necessarily special ethical principles or the validity of information. In all cases the psychologist should attempt to review the material which is to be published before giving his permission to any reporter or newspaperman for such publication. This may avoid a good deal of embarrassment. This happened several years ago:

A clinical psychologist spoke before a Rotary Club on the topic of "The Role of Anger in Emotional Tension." During the course of his lecture the psychologist gave examples of certain patients who, by withholding their anger, suffered physical and emotional tensions. Following the lecture, a well-known local columnist asked the psychologist for some of his time in order to get some notes about the lecture. The psychologist answered freely all of the specific questions put to him by the columnist, and then asked the columnist what he planned to do with the information. The columnist said he would present a review of the speech which was given, and no further discussion occurred. The following Sunday the psychologist was chagrined to open his newspaper and find in the paper's magazine section a cartoon-filled article entitled "If you have a headache beat your wife." In this article the columnist humorously extracted one particular section of the psychologist's comments having to do with headaches sometimes being based on anger which is "held in." The columnist reversed the situation and suggested that if this be the case, the easiest way of handling it would be to express anger on the person who is most likely to absorb it without recrimination—the wife. It is perhaps questionable whether the psychologist could have prevented publication of such an article. It is possible, however, that the columnist could have been interested in making a more scientific and valid presentation of the psychologist's speech.

No book, publication, pamphlet, or set of rules can cover ethical standards for the private practice of clinical psychology. Ethical standards, by and large, must be a part of the philosophy and

character of the individual professional person. We can say that the building of an individual's character begins in childhood, but little can be done to select and effect good ethical standards in children who are likely to become psychologists. The most appropriate place where these matters can be considered is the gradulate school which prepares the clinical psychologist for his active role as a professional person in the community. Some attention is now being paid to thiś matter and we can anticipate that more training and supervision in the nature of ethical standards may soon develop.

# CHAPTER 12

# Fees

THE DISCUSSION OF FEES in the private practice setting occurs here as a matter of expediency and not importance. Psychologists in the community practice setting find this to be a complex problem. Psychology is one of those professions which has little or no experience with placing monetary value on professional services. As a result, psychologists who enter private practice have very few guideposts in this direction.

Setting fees in private practice produces anxiety in most psychologists. When a professional person sets a fee on his work he is literally placing a value on himself. Although psychologists, particularly clinical psychologists, have experience in self-evaluation from the therapeutic framework, they seem to have difficulty transferring this experience to the practical problem of setting fees.

When a patient comes to see a psychologist he fully expects to pay for services rendered. Anxiety about fees often seems to be more intense with the psychologist than with the patient. For this reason, detailed attention will be paid to the question of setting fees.

## THE WORTH OF PSYCHOLOGICAL SERVICES

No published set of monetary values for psychological services exists at present. A wide variety of fees may be found in different sections of the country. It will be very important for the clinical psychologist who anticipates private practice to do some soul-searching in terms of his capacity of setting monetary value on services which he renders. Many formulas for setting fees have been attempted. Some psychologists set fees in terms of the kind of service rendered, roughly equivalent to the technical medical services such as X-ray and laboratory work. Thus, Rorschachs are given at the rate of $35 each, Wechsler-Bellevues at the rate of $25 each, and so forth. Other psychologists feel that this is unrealistic, and that services must be charged for on the basis of time spent with the patient. Some psychologists use a combination of these techniques. Both sides of the picture will be examined. There is no question, however, that before a psychologist can enter the private practice setting he must be prepared to set a value on himself and the services he is likely to render to the patient.

## THE SETTING OF BASIC FEES

The setting of basic fees for psychological services to some extent must depend on the conditions in the community where the psychologist practices. Unless the psychologist is the only person in the behavioral sciences practicing in the community, he will be aided in setting his fees by examining what is charged by other professional persons: psychiatrists, psychologists, social workers, and other behavioral science specialists.

Fees on the basis of time spent with patients will vary in different parts of the country. At the time of this writing, many psychologists in the city of New York have set a basic fee of $20 per session for professional work. A large number of psychologists in Los Angeles, California have set a basic fee of $25. Detroit, Michigan psychologists are trying a general agreement that $10 per session

should be the basic time-fee for psychological services. Psychologists in the majority of cities in Florida set a fee of $20 per session.

This time-fee basis generally relates to psychotherapeutic time. It will be found that such a formula applied to diagnostic functions will result in a considerable fee if any amount of testing is done. For this reason, in those cities where the basic psychotherapeutic fee is $20 per session, diagnostic services are generally charged at the rate of $15 per hour, including time for working up the material and dictating the reports. This is somewhat reasonable in terms of the comparative difficulty of diagnostic and therapeutic work.

In calculating the basic fee, where the time-fee method is used, a summation of the time utilized in diagnostic or therapeutic functions is sufficient to determine the fee. If the psychologist decides to use the job-fee method, that is, setting a fee for each psychological procedure administered, he would have a list of psychological tests or procedures from which he can calculate his fee. Once all procedures have been accomplished, the setting of the fee is completed.

One of the considerable problems that faces all specialists in human behavior dealing in the private practice setting is the availability of such services to people of medium and low income. Ordinarily a psychological evaluation will cost between $65 and $150. If psychotherapy at the rate of one session per week is recommended, this means a cost of over $80 per month to the patient. This is unrealistic in many family situations, and the psychologist must face the alternative of having a discriminatory practice, or basing his fee on income. The ethical standards of all professions indicate that services must not be refused on the basis of income. This does not necessarily mean that all professional people follow this standard. Such a standard is recommended for psychologists in private practice.

An arbitrary scale may be worked out to calculate fees based on income. This will vary according to economic conditions and responsibilities, but generally the following scale is recommended:

1. For incomes above $7500 per year—*full fee.*
2. For incomes between $6000 and $7500 per year—*three-quarters fee.*
3. For incomes between $5000 and $6000 per year—*half fee.*
4. For incomes below $5000 per year—*based on the clinician's judgment in reviewing the responsibilities of the individual patient.*

The above cannot be used as a rigid formula. For instance, a single man earning $6000 a year is ordinarily well able to pay a full fee. Conversely, a man who earns $7500 a year who must provide his wife and himself with psychotherapy, and who must in addition to this support five children is in no position to pay a full fee. Only judgment and experience can help the clinician set fees in a reasonable and appropriate manner.

## DISCUSSING FEES WITH THE PATIENT

Ordinarily the patient will not initiate questions concerning the fee. This responsibility lies with the clinician. Discussion of fees will best occur at the earliest reasonable time during professional contacts. After taking the clinical history, the psychologist should be able to estimate the income of the family. He may not at this time wish to set his exact fee because he isn't in a position to know the exact services he will render during the diagnostic phase. Fees, however, should be discussed with the patient at this time, and the patient should be given some indication of what the range of fees might be for the anticipated work. If, during the evaluation, the psychologist discovers that additional work will be necessary, this should not be instituted without first discussing the additional fee commitment with the patient.

Perhaps the most important place for the discussion of fees occurs in therapeutic contacts. Money is certainly very dynamic symbolism and is often used as a vehicle for resistance in the therapeutic setting. It is the psychologist's responsibility to handle re-

sistance which involves fees as any other form of resistance. When discussion of fees arises in psychotherapy, questions should never be dismissed hastily, or given simple answers. The dynamic implications of the patient's attitude toward fees should be discussed and worked-through.

Whenever possible the patient himself should be responsible for the fee. If the psychologist has a choice of receiving a full fee from a parent or guardian or a partial fee from the patient, the psychologist should consider the lower fee in order that his patient may gain a measure of independence which will hasten and make more effective the therapeutic procedure. This, of course, is almost impossible with younger patients, but should be a primary consideration with adolescents and adults.

## SPECIAL CONSULTATION FEES

As indicated in Chapter 10, the psychologist will often have an opportunity to establish consultative and collaborative relationships with agencies and individual professional people in the community. Ordinarily, fees for this type of professional service are lower than the fees received from regular patients. Just why this is so is dependent on a number of factors. In agency settings, consultation fees are often set by a state or municipal agency and are not under the control of the consultant, or the professional people with whom the psychologist may work. Second, intraprofessional contacts are often set at a lower fee when they are on a regular basis. A third point of consideration, which is seldom discussed but nevertheless of vital importance, is that during these intraprofessional contacts the psychologist is likely to derive certain professional and personal benefits.

## PROFESSIONAL COURTESY

Some discussion about professional courtesy can be found in *Ethical Standards for Psychologists* (*32*), published by the Ameri-

can Psychological Association in 1953. Broadly, the A.P.A. recommends that psychiatrists, social workers, and other psychologists be given full professional courtesy. It further recommends that physicians be seen at half rates, or modified professional courtesy. A third recommendation is that dentists be seen at a three-quarter fee.

One clinic has attempted to apply this formula in the private practice setting for a period of five years. They frankly found that it did not work. In some instances, the physician will give the psychologist in private practice full professional courtesy, and psychologists can do nothing less than return this. In other instances, psychologists find themselves charged full fees by physicians with whom they deal personally.

The following recommendations are made: The psychologist must adapt his philosophy of professional courtesy to the community in which he practices. Although to some extent he must depend upon the situation existing in the community, the psychologist himself is responsible for evaluating whom he will service on a no-fee basis and when he will charge professional fees. It is probably a good standard policy to give some form of professional courtesy to all medical people. Insofar as the dental profession is concerned, the psychologist should follow his feeling about his community and his own attitudes. With behavioral science specialists, there is no question that full professional courtesy is indicated for diagnostic work. Except with children, no therapeutic work should be done on a no-fee basis. With adult patients, the opportunity for independence and responsibility should always be made available to the patient through the setting of a fee.

Once the psychologist is established in private practice he will face certain conflicts in minor problems involving professional courtesy. He may take his child to a pediatrician he met at a civic club or Parent-Teachers Association and find that this pediatrician charges him full fee for medical services. The psychologist will perhaps have a feeling of antagonism toward this particular pediatrician, since most psychologists in private practice expect some

sort of professional courtesy. The psychologist would be wise to chalk this experience up to the inexperience of the pediatrician involved. It is seldom that this is a hostile gesture by another professional person. Very few medical people consider the psychologist associated with the medical profession and, indeed, the psychologist does not wish such an association. The psychologist, therefore, has no intellectual reason for feeling hostility when professional courtesy is refused. Such hostility does arise. Often psychologists indicate that they base their professional courtesy fees on the way other professionals treat them. This is unavoidable to some extent, that is, should psychologists have an opportunity to require legal services, and find that the attorney involved refuses to charge a fee, the psychologist can only reciprocate when the attorney comes or sends his wife for professional services. On the other hand, once the psychologist sets a policy for professional courtesy, it is probably unwise for him to modify this because he feels that a certain professional person has not reciprocated. Thus, if the psychologist decides to set half-fee for physicians, and his own physician comes for service, the psychologist should not charge a full fee simply because his physician has done so in treating the psychologist. The only way these situations can be clarified over a long-range period is for one side of the conflict to "hold still."

## COLLECTION OF FEES

This is a constant and difficult problem in professional practice, whether it be for psychologists, physicians, or architects. Very few professional people collect their fees "at the door." In certain cities the dental profession has set up a procedure by which a patient must pay his fee not only immediately following service, but often before service is rendered. In other communities, some professional people effect liaison with a special credit agency whereby a patient unable to afford service is able to take out a loan and sign a note for his fee. Such practice is discouraged. If fees are set in a realistic

manner, it will be unnecessary to utilize the service of loan companies or demands for prepayment.

Surveys indicate that the average physician in the United States is able to collect approximately 72 per cent of the fees he actually charges. To some extent, this will be an indication of what the psychologist preparing for private practice may expect of the amount for which he actually sends bills. Certain methods are effective in raising collections as high as 92 per cent. The first step in such a procedure is to set fees realistically. Using the fee-based-on-income method usually eliminates a good deal of the fee collection difficulty encountered in private practice. A second valuable procedure is to instruct the person who is in charge of bookkeeping for the office to gently remind each patient when the bill begins to exceed a certain limit which will be arbitrarily set by the psychologist.

In the event that the above methods fail, the psychologist must make his choice as to whether he will forget the delinquent debt or take steps for collection. Steps for collection usually involve several things. The first usual procedure is a series of semi-insistent letters, followed by referral of the bill to a collection agency should the letters fail. A third and more drastic step is the referral of the bill to a lawyer and filing suit in small-claims court. All of the above procedures are to be discouraged. The cardinal principle in fees is the reasonable setting of such fees at the onset of service. This prevents a host of problems and conflicts. Once these conflicts arise they are practically insoluble in a conservative professional manner. Debts over two years old may well be forgotten.

If fees are set after careful evaluation of the patient's ability to pay as well as open discussion of the patient's responsibility in this matter, a minimum of difficulty will be encountered.

An allowance of 30 to 40 per cent of the case load can be accepted on a low-fee basis and still provide the clinical psychologist in private practice with a very comfortable income. This manner of practice—fee based on income—is quite appropriate to the social service nature of psychology as a profession.

# CHAPTER 13

# The Clinical Psychologist and the Legal Profession

UNTIL RECENTLY, there have been only rare instances where psychologists have appeared in courts of law as expert witnesses. To quote a renowned jurist (*68*):

. . . Nevertheless, within the limitations of these special judicial rules [pertaining to partisan presentation of evidence in an adversary proceeding], judicial practice is entitled and bound to resort to all truths of human nature established by science, and to employ all methods recognized by scientists for applying those truths in the analysis of testimonial credit. Already, in long tradition, judicial practice is based on the implicit recognition . . . of a number of principles of testimonial psychology, empirically discovered and accepted. In so far as science from time to time revises them, or adds new ones, the law can and should recognize them. Indeed, it may be asserted that the Courts are ready to learn and to use, whenever the psychologists produce it, any

method which the latter themselves are agreed is sound, accurate, and practical. If there is any reproach, it does not belong to the Courts or the law. A legal practice which has admitted the evidential use of the telephone, the phonograph, the dictograph, and the vacuum-ray, within the past decades, cannot be charged with lagging behind science. But where are these practical psychological tests, which will detect specifically the memory-failure and the lie on the witness stand? There must first be proof of general scientific recognition that they are valid and feasible. The vacuum-ray photographic method, for example, was accepted by scientists the world over, within a few months after its promulgation. If there is ever devised a psychological test for the valuation of witnesses, the law will run to meet it. Both law and practice permit the calling of any expert scientist whose method is acknowledged in his science to be a sound and trustworthy one. Whenever the Psychologist is really ready for the Courts, the Courts are ready for him.

Since 1953 (*69*) psychologists have become increasingly concerned and interested in their seldom-practiced but potentially major role as expert witnesses testifying on varied phases of human behavior (*70, 71*). Descriptions of such court appearances have received some attention and discussion (*72, 73, 74, 75, 76*).

The clinical psychologist in private practice is in a likely position to be used as an expert witness in matters concerned with human behavior. Being an active and participating member of a community, the psychologist and his particular professional skills are more likely to come to the attention of attorneys and the courts than psychologists in academic or agency settings. Although psychologists as a group might testify concerning broad and varied concepts and situations involving human behavior (*69*), certain specific areas seem to fall in the province of the clinical psychologist.

## QUALIFICATIONS OF EXPERT WITNESSES

Part of the recent efforts in many states to certify and license psychologists has included specific statutory designation of qualified or certified psychologists as experts in human behavior for purposes of judical testimony (77). In most states, as well as in

federal court proceedings, the qualification of an expert witness occurs in the court, subject to evaluation by counsels and ruling by the court.

From the judicial point of view, *expert* is a broad and fluid term. By and large, psychologists have been accepted as expert witnesses in their particular professional skills (*68*). In point of fact, cases in which a psychologist's testimony was stricken from the record have been successfully appealed with the exclusion of a psychologist's testimony as the noted trial error (*74*).

Insofar as determining levels of competency as an *expert* in psychological matters, the dividing lines are vague. We will assume that a clinical psychologist, sufficiently trained and experienced to practice privately, is capable of giving testimony within the areas of his practice and competence. In any event, final determination of a psychologist's competency as an expert witness will fall within the province of the court.

In the question of the qualification of an expert witness to address the court, The American Law Institute Model Code of Ethics states:

> A witness is an expert witness and is qualified to give expert testimony if the judge finds that to perceive, know, or understand the matter concerning which the witness is to testify, requires special knowledge, skill, experience, or training, and that the witness has the requisite special knowledge, skill, experience, or training.

## RESPONSIBILITIES OF THE EXPERT WITNESS

Just as the psychologist as a scientist has hesitated to apply the available knowledge of the profession in private practice (see Chapter 1), there is often a hesitancy in appearing as a witness in court. Many psychologists feel that a courtroom appearance would subject them to embarrassing or even frightening experiences with hostile attorneys who would demand a "Yes" or "No" answer to broad, unspecific questions. As Louisell (*68*) points out, such procedures are more characteristic of stage plays and movies than actual courtroom procedures. Louisell further points out:

This is often an unjustifiable and immoral attitude which engenders public antipathy to professions whose members excessively indulge this attitude. The very definition of profession implies public service as well as profit, and professional *noblesse oblige* dictates performance of obligations to judicial administration as not the least of public service.

Insofar as the psychological profession is concerned, the American Psychological Association in its *Ethical Standards of Psychologists* (*32*) states:

> When testifying as an expert witness, a psychologist should make only such statements as he is qualified to offer on the basis of his professional training and experience, and which he can substantiate by evidence that would be acceptable to recognized specialists in his same field. Princ. 1.22-2.

Although the psychologist performing as an expert witness should express opinions substantiated by reasonable psychological evidence, it should be quite clearly understood that such expressions on the witness stand are *opinions* and not facts. The expert witness has the responsibility of delivering these opinions. It is the court or the jury which must decide the degree of confidence to be placed in the expert witness's testimony.

The expert witness has a complete choice in the material he uses in substantiating his testimony. He further has the opportunity of expressing a "No opinion" answer to questions placed before him.

Thus, it becomes apparent that the preciseness and form of an expert witness's testimony depends to a large extent on his area of specialization, degree of contact or observation with the legal matter under consideration, and his willingness to express opinions concerning the situation. It would be assumed that professional psychologists are well able to qualify in the role of expert witness in specific situations. To insure adequate performance in this role, the average clinical psychologist who expects to become an expert witness would do well to become well acquainted with courtroom procedure and protocol, particularly in respect to his state's laws governing testimony by expert witnesses.

## AREAS OF TESTIMONY

Since the field of psychology encompasses all of human behavior, the specific subject of a psychologist's testimony would appear to be nearly unlimited. Experience indicates certain specific areas in which psychological testimony *has been given*. Future liaison between the legal and psychological professions will probably result in a broadening of the role of the psychologist as an expert witness. For the present, we will consider what is likely to be required of a clinical psychologist in private practice.

### *Sanity Hearings*

The original formula for criminal responsibility was presented in the *McNaughton Rules* in 1843. Fundamentally, these tenets state that the essential issue in an insanity plea involves determining whether the accused was capable of knowing *right* from *wrong* at the time of the crime. Psychiatric and legal criticism of this concept has been frequent and intense since its publication. Nevertheless, despite active support for a more realistic concept of *sanity*, the early rule prevails (*78*).

Until specific changes in statutory definitions of insanity are made, the clinical psychologist will still be examined specifically in regard to whether the patient *knew* what he was doing.

In giving testimony, psychologists often rely on their specialized examining tools, such as projective techniques, on which to base their opinions. The presentation of written reports and the use of standard, professionally acceptable tools of evaluation do much to add to the authority of the clinical psychologist's testimony on the witness stand. This generally positive reception of the psychologist's methods calls for the most careful and conscientious use of these tools.

### *Post-Traumatic Deficit*

The general capacities of an individual following physical or mental trauma are of great importance in Claims actions. Whereas

medical testimony has been the primary means of determining the residuals of a physical or emotional trauma, clinical psychologists have been utilized with increasing frequency. Aside from measures of personality disturbance, the psychologist is often in a position to indicate the extent of intellectual and behavioral deficit resulting from organic injury.

When a psychologist is called upon to examine an individual who has supposedly received injuries which affect the psychological functioning, one of the most valuable preliminary steps to be taken is to determine whether standard psychological tests have been given the individual previous to the accident. Checking school records, family history, employment records, and the like, sometimes results in finding valuable psychological test data which may be considered as indicative of premorbid functioning. Such data must be examined with great caution and a thorough awareness of the limitations of the tests being considered. Administration of equivalent forms of these tests may help the psychologist form a more definite opinion as to the individual's "loss" as a result of the accident or trauma.

### *Competency*

Involving either institutional eligibility, commitment adjudication, or financial responsibility, the courts are often the arbiters of an individual's intellectual or emotional capacity to make justifiable and competent decisions and thus retain his civil rights. Such legal action is usually brought by family members to alleviate a situation in the home which may or may not be socially or physically tenable.

In such cases, individual differences are of great importance. Where the case involves a child of low intellectual endowment, where the parents are seeking adjudication to the state farm colony or home, the matter is relatively simple.

Complexities tend to arise in those cases where an individual is brought to court by family members who feel that the accused is incapable of handling funds. Where considerable money is in-

volved, the issue tends to be most difficult. In this context, the psychologist must examine the patient to determine whether incompetency, either by reason of psychosis or impaired intellectual ability, truly exists. Differentiation between *eccentricity* and *psychosis* must always be considered. *Example A* at the close of this chapter illustrates a psychologist's testimony in such a case.

### *Child Custody*

Though a relatively new area, the clinical psychologist in private practice is sometimes called upon by plaintiff or defendent to present findings or opinions in regard to the psychologist's examination of a child of parents "battling" for the child's custody. Such testimony must be most carefully rendered. Primary responsibility here lies in the psychologist's most conscientious evaluation of the child's behavior, development, and needs.

It can be expected that over 90 per cent of cases involving psychologists' evaluations never reach the courtroom. Most of the civil actions are settled out of court, while many of the criminal cases are arraigned and adjudicated without formal trial. Juvenile Court procedures are particularly informal and flexible. Nevertheless, in all cases, the psychologist who is retained to evaluate a potential court case would do well to conduct his examination and construct his report with every expectancy of presenting himself as an expert witness. The inadequately prepared expert witness is a disgrace to the attorney who retained him as well as to his own profession—publicly and often with the press fully represented.

## PREPARING THE ATTORNEY

In dealing with the legal profession, the psychologist who is asked to be an expert witness should be prepared to be both teacher and student. Generally, it is the psychologist's job to explain to the attorney the extent and limitations of psychological knowledge, methods, techniques, and communication. In return, the psychologist would be wise to "listen much" and learn something of the

complexities of one of civilization's oldest professions. These complexities are often frustrating and seemingly bulky. The judicial system of our culture, however, is the result of thousands of years experience in attempting to codify and formalize the rights, privileges, and dignity of man. The difficulties of such a task should meet sympathetic understanding among psychologists.

In addition to a written report of examination, the psychologist should provide the attorney with the following information:

1. Full name
2. Degrees, dates of conference, and university
3. Present position, title, and general description of duties
4. Pertinent past experience
5. Professional affiliations
6. Honors, publications, or significant professional offices, licenses, or achievements

In addition to the above, where the psychologist is listed in any standard professional directory, this should be brought to the attorney's attention.

Most attorneys will review the kinds of questions that are likely to be asked in order to best prepare the expert witness for his role. This, however, is not always the case. In any event, the psychologist will not be expected to answer unreasonable or meaningless questions with a blanket "Yes" or "No."

## BEHAVIOR ON THE WITNESS STAND

The first step in the psychologist's debut in the courtroom involves the qualification of him as an expert witness. This may or may not be a difficult business. The opposing attorney has every right to question any "expert witness." Final determination of the competency of an expert witness lies with the judge. When a psychologist is rejected as an expert witness, he is merely excused from the witness stand. Such excusals have often proven to be trial errors and have resulted in the granting of an appeal (*68*, *74*).

Although a rare occurrence, the psychologist may be "badgered" by a hostile attorney. A wise rule on the witness stand is to be well prepared, take one's time, answer only those questions which are within the witness's *professional* domain, and under *no* circumstances try to do battle with the examining counsel.

One of the significant challenges that occur in the courtroom has to do with the title *Doctor* and whether the psychologist is entitled to its use when an expert witness. Recent discussion (*79, 80, 81*) indicates that this matter can be handled readily and to the psychologist's advantage. In a number of cases where the use of the title *Doctor* has been challenged, reference to the major graduate programs granting the Ph.D. degree has been an important clarifying device. Further reference to the roles played by psychologists in the Veteran's Administration, service programs, and guidance centers has usually established the psychologists' legal right to the title. Meaningless as such a conflict may seem, the matter can be of considerable importance in the courtroom.

There are no stable rules and regulations for the functioning of the clinical psychologist as an expert witness. Each case is unique. Adherence to usual professional standards seems the most applicable "rule of thumb." Two examples of psychologists functioning as expert witnesses are herein presented to clarify exactly how two expert witness situations developed.

## EXAMPLE A—DEFICIT

A five year old male child was severely shocked when he came into contact with exposed 110 volt current in an unfinished home in his neighborhood where several children were playing. A suit for damages was brought against the electric contractors and the general contractors. The psychologist involved was asked to examine the child by a psychiatrist to whom plaintiff's attorney had originally referred the youngster. A written report, primarily indicating post-traumatic effects of the accident, was submitted. In this case, no preparation between the psychologist and the attorney

occurred. The following transcript is taken verbatim from the trial transcript. The names of professional persons have been changed as a matter of courtesy.

IN THE CIRCUIT COURT OF THE THIRTEENTH JUDICIAL CIRCUIT IN AND FOR THE COUNTY OF HILLSBOROUGH, STATE OF FLORIDA. AT LAW.

RICHARD ROE,
Plaintiff,
vs. No. 31387-L
E. H. JONES, doing business as
JONES ELECTRIC COMPANY,
Defendants.

TRANSCRIPT OF TESTIMONY Taken Before
HONORABLE L. L. PARKS,
Circuit Judge

In Courtroom Number One, Hillsborough County Courthouse, Tampa, Hillsborough County, Florida, on Friday, June 14, 1957 beginning at 9:00 A.M.

*Testimony of* DR. JOHN DOE

Present:

HON. E. B. ROOD and HON. DOYLE M. CARLTON, of the firm Mabry, Reeves, Carlton, Fields, and Ward, Attorneys for Plaintiff.

HON. G. T. SHANNON, of the firm Shackleford, Farrior, Shannon, and Stallings, Attorneys for Defendant.

HON. C. F. CLARK, of the firm Macfarlane, Ferguson, Allison, and Kelly, Attorneys for Jones Electric Company.

*PROCEEDINGS*

Thereupon,

DR. JOHN DOE,

a witness, called and being duly sworn for and in behalf of the plaintiff, testified as follows:

*Direct Examination*

By Mr. Rood:

Q. Will you please tell the jury your name, please sir.

A. John D. Doe.

Q. Your profession, please Doctor.

A. I'm a clinical psychologist.

Q. Would you tell us where you are a clinical psychologist.

A. I practice privately with a group of psychologists at 420 W. LaFayette St., this city.

Q. That's here in Tampa?

A. That's here in Tampa.

Q. Would you tell the jury, Doctor, a little bit about your training, college training, and the experience and training you have had since.

A. I hold the Bachelor of Arts Degree, Master of Arts Degree, and Doctor of Philosophy Degree in Psychology from the University of Denver, Denver, Colorado. I did my clinical internship training at the Colorado Psychopathic Hospital in Denver, Colorado. I have spent two years in Yankton State Hospital, Yankton, South Dakota as Chief Clinical Psychologist. That was prior to my coming to Tampa where I now practice. I am consulting psychologist at Anclote Manor, a neuropsychiatric hospital in Tarpon Springs. I belong to the various professional organizations in my field such as the American Psychological Association, the Southeastern Psychological Association, the Florida Psychological Association, the Society for Projective Techniques and Rorschach Institute.

Q. Does that about cover it?

A. Yes, sir.

Q. Now, Doctor, was a child named Richard Roe referred to you for study by Doctor Smith sometime this year?

A. Yes, sir. He was.

Q. Would you tell us when that was?

A. May I refer to my report?

Q. Yes.

A. I saw Richard on March 22, 1957.

Q. What did you do at that time, please Doctor? Tell us what examinations you made, if any, and what sort of history you got and whatever you did.

A. All right. Psychological examination was made in which I administered the Draw-a-Person Test, which is a personality test, The Stanford-Binet Intelligence Test, Form L. The Full-Range Picture

Vocabulary Test, Form A, and the Vineland Social Maturity Scale. These tests were given to understand this boy at a deeper level and to understand his intellectual abilities at this time and to see if there was any relationship to his behavior at this time in relation to the accident.

Q. What history was given to you about the accident?

A. I had the history that he had touched an electric wire and –

Q. Was the time given you?

A. It was July of 1956, I have here.

Q. So, you knew then the type of accident he had had?

A. Yes, I did.

Q. Now, Doctor, did you find any relationship between that electric shock and his present condition?

A. Well, first of all I would like to go into the test material, if I may.

Q. All right.

A. The first intelligence test that was given was the Stanford-Binet, which is one of the most well-known tests that is used today throughout the nation. His chronological or life age at that time was five years and five months. His mental age was four years and six months, and his IQ was 83. The comparison of the life age and mental age gives us an idea of the individual's ability to learn and his capacity to deal with other youngsters his age, and then we convert this into IQ for clarity, easier to use in the school system and other situations. This 83 places him within the lower range of average intelligence. To further understand the intelligence here, I ran another test which dealt more with his verbal capacity, his ability to express himself, and he obtained a mental age of five years, two months and an IQ of 95 on this test. Which means he was right in the average range on the second test that I gave him. There is a difference of testing between these two tests that I administered in that the Stanford-Binet is what we call a non-verbal test in which he is given instructions and then goes through to complete the various examinations such as using his hands and eyes to solve various problems and ponder them. The other test is a verbal test in which he must express himself with words, and think in terms of words. So, that might be some of the reasons for the difference in the two testings.

I then took a Vineland Social Maturity History from Mrs. Roe. Now, this is getting at his developmental picture. The socializing, the ability to take care of himself. In comparing him with other boys and girls his age to see if he is up to par as far as dressing himself, as far as responsibility and social awareness. Now, the first history that I took from Mrs. Roe indicated that I wanted to know what was his behavior

before the accident and I confined it only to that period. At this point, we obtained an age equivalent of six years, three months or a social quotient of 115. I then took a history aiming at how has he been since the accident and he gave out with an age equivalent of four years, eight months or a social quotient of 86. On the social quotient, some studies have been done and it compares fairly close to the Stanford-Binet scales which was the first intelligence test which I gave and he came out with an 83 IQ on that.

I then ran a personality test to see what emotional problems I might be able to find. Also, I observed him clinically in terms of his behavior. He was a very impulsive lad, which means that his attention was fluctuating. It was difficult to keep him in any one spot for any length of time. He seemed to have a great deal of tension and anxiety within him. At the conclusion of this, I ran a visual motor control test which measures, indirectly, brain function. But because of inability to gain proper attention span I ruled this test out as not valid. That was essentially the psychological examination.

Q. Doctor, from those four or five tests, one of which you ruled out, did you determine whether there was emotional maladjustment in this child?

A. Yes.

Q. Did you determine whether or not there was also probable brain damage involvement?

A. With the type of behavior exhibited, there could possibly be.

Q. Doctor, is there any way of telling how long this maladjustment may last?

A. Are you saying will it work itself out?

Q. Well, just you tell us what your prognosis is, if you have one.

A. I feel this way, that at the present time, or at the time I tested Richard, if his present state continued, it would increase. It would become more difficult and he would become more emotionally disturbed and that I felt he should have some definite treatment in the form of psychotherapy.

Q. What would that treatment cost?

A. Now, in dealing with this type of problem, and I must approach it from my own opinion here, I feel that the boy would need psychotherapy and the mother would also benefit from it. So, it would take a joint approach.

Q. What would the part the boy would need cost?

A. I would say somewhere in the neighborhood of $300 to $500.

Q. Doctor, can you tell us whether or not this maladjustment from the accident will affect his ability to work in the future?

MR. CLARK: If Your Honor please, I don't know that the Doctor has testified that the maladjustment was a result of the accident.

MR. ROOD: Well, I've just asked him that question before, whether he found any maladjustment —

MR. CLARK: You asked whether or not the maladjustment will affect him in the future —

MR. ROOD: All right.

Q. Well, Doctor, can you state with a reasonable medical certainty whether this experience this boy went through in July, as related to you, could be the competent producing cause of the condition you found?

MR. CLARK: If the Court please, I object to that. He had no experience with this boy before this experience and I don't think he can ask him whether or not in his opinion —

THE COURT: I think that's right—

MR. ROOD: I asked him, within reasonable medical certainty. That's what I asked him. No doctor can be positive about anything.

Q. Within reasonable medical certainty, Doctor, could the experience as related to you in July of 1956, be a competent producing cause of the conditions that you discovered from these tests?

A. If you can change that medical, I can answer it. I'm not a medical doctor.

Q. Well, in your field —?

A. In my field I would say that in regard to his emotional problem, I feel any type of severe or strong situation, such as home situations or the accident, could aggravate the situation.

Q. In other words, it's a matter of aggravations in your field?

A. That's right.

Q. Now, tell us whether or not this aggravation could affect his future employment.

MR. CLARK: Your Honor, I think that is highly speculative —

Q. Well, will it affect his future life?

A. If no treatment is given the boy at this time, and he continues in the state that he is, it will affect possibly his vocational as well as his social adjustment.

Q. Why do you say that? For what reason will it do that? What effect will it have?

A. It will make it difficult for him to adjust.

Q. To what?

A. Adjust to life itself.

Q. Then you advise this treatment?

A. I feel he needs psychotherapy, yes.

MR. ROOD: That's all.

*Cross Examination*

By MR. CLARK:

Q. Doctor, did you inquire into the home problems involved here at all?

A. Not extensively. I did not take a full history.

Q. Normally, in evaluating an individual, that would be the proper thing to do, wouldn't it? If you're looking for emotional situations such as this, wouldn't it be the normal thing to do?

A. Well, let me put it this way —

Q. Have you ever been in the home —?

A. No, sir.

MR. ROOD: May he answer the question, Your Honor? Mr. Clark asks the questions and then doesn't give him time to answer.

MR. CLARK: The Doctor said no.

A. (*Continuing*) This was a referral case from Dr. Smith, and in this type of referral case, the referring doctor takes the history and —

Q. You don't know much about the home life of this boy?

A. I do not know much about the home life.

Q. That would make a most important difference, couldn't it?

A. It could have a bearing upon the situation.

Q. Matter of fact, the home life would be probably the most important environmental factor in the personality picture?

A. Home life would be a very important factor.

Q. I believe you said either home life or an accident of this kind could produce the personality symptoms of which we are talking about?

A. No. I stated that the type of situation that took place, the accident could aggravate the situation, the emotional adjustment.

Q. In other words, the emotional situation was already there, wasn't it?

A. It could have already been there, and in my opinion it probably was.

Q. If you knew about the home life you would have a perfect basis for looking for this, this —

A. If I knew more about the home life I would have a deeper understanding of this youngster.

Q. Did you know that he was in a broken home?

A. Yes, I knew that.

Q. Did you find, that in your examination it produces tension?

A. It certainly can.

Q. You had examined this child on one occasion?

A. One occasion.

Q. That was on March 22, 1957?

A. Yes, sir.

Q. Immediately before this trial and the trial was continued?

A. I don't recall the trial. In fact, I wasn't sure this was even coming up for trial when I tested this lad.

Q. That was on the 22nd of March and this case was set on the 26th, and Dr. Smith didn't tell you this?

A. No. This was a rush case and I hadn't had a chance to talk to Dr. Smith to any extent.

Q. You hadn't had a chance to talk to Dr. Smith to any extent?

A. To any extent. Not to get right down to cases.

Q. You haven't seen the child since or given any therapy?

A. I'm trying to think because I had another conference with Mrs. Roe. I don't recall whether I did see him at that time or not. I don't believe I did.

Q. You said something about the mother needing some emotional therapy.

A. Yes, sir.

Q. Why do you say that?

A. It goes on my opinion in dealing with emotional problems of children. When treating both the child and the mother, the amount of success in the case is certainly very encouraging.

Q. In short, you treat the mother with reference to how to treat the child, and deal with the child. Is that right?

A. Treat the mother in terms of understanding herself at a deeper level and in turn understanding her children.

Q. To iron out whatever conflict there may be between them?

A. Sir?

Q. Is that to iron out whatever conflict there may be between them?

A. Not necessarily between them, but within the mother or within her feelings about other people. It doesn't have to be a direct relationship between mother and child.

Q. You do this testing of children for parents, don't you?

A. Yes.

Q. From day to day?

A. Yes.

Q. Isn't your most important consideration the type of home life the child has?

A. I wouldn't say the most. You must deal with the total situation. The home life plays a very important part.

Q. School life?

A. School life plays an important part.

Q. What they do with their spare time —?

A. His friends and the whole situation.

Q. You try to iron out the difficulties between the parents and the child?

A. That is correct.

Q. And you're purely a psychologist and not a Doctor?

A. No. I'm a Doctor.

Q. Not a Doctor of medicine?

A. Not a Doctor of medicine, no.

Q. Or a neurologist, or anything like that.

A. I'm a clinical psychologist.

Q. You're a Ph.D. but not an M.D.

A. Right.

Q. Did you have a history of this child playing around immediately after this occurrence took place and in telling his friends about what happened —?

MR. ROOD: May it please the Court, there is not one bit of evidence that that ever happened. Mr. Hall said he saw a child and wasn't sure how soon and he didn't know whether it was the brother or who it was. There is no evidence at

all that this child was playing that afternoon and I object to it.

THE COURT: Objection overruled.

By MR. CLARK:

Q. Were you given that kind of history that he was kind of proud of this thing and kept telling the other children about it?

A. No, sir. I wasn't given that kind of history.

MR. ROOD: I don't think he can ask a question on something that's not in evidence.

THE COURT: I don't know about him telling other children, Mr. Clark —

MR. CLARK: I'm going to show that he was playing around that day and appeared perfectly normal.

THE COURT: Yes, but you're asking about him talking and saying things about it. That's what Mr. Rood objected to.

A. (*Continuing*) If I may I could indicate here the amount of history I have. If you would like to hear it.

Q. Did you get the history from the mother?

A. No, this was from Doctor Smith.

Q. In other words, you got it secondhand?

A. From Doctor Smith.

MR. CLARK: I believe that's all.

*Redirect Examination*

By MR. ROOD:

Q. Doctor, were the reports and tests and results of the tests made and sent to Doctor Smith?

A. Yes, sir.

Q. It wasn't sent to me?

A. It was sent to Doctor Smith.

MR. ROOD: That's all.

*Recross Examination*

By MR. CLARK:

Q. Your conclusion is based on what the mother said through Doctor Smith. Isn't that right—about the behavior of the child?

A. Now, in terms of my testing—I was given a specific test to measure his intellectual abilities, emotional development, personality structure, and observe his behavior.

Q. You had never seen the child before?

A. Before that I did not see the child.

Q. You did not have any idea of his attention span or anything like that?

A. I did not observe him before I tested him.

Q. Everybody has a different attention span, don't they?

A. Well, certainly. We get into individual differences there and we have to go on our knowledge of children in when you indicate a short attention span or a long attention span. It was my knowledge of five-year-old children that indicated this boy had a short attention span.

Q. Lots of kids five-years-old have short attention spans, don't they?

A. A five-year-old has a short attention span, but what I'm saying is this boy, for a five-year-old, had a shorter attention span than most five-year-olds. That's what I'm trying to indicate.

Q. Isn't that sort of hereditary with an individual what his attention span is?

A. No, sir. It's learned.

Q. It's learned?

A. Yes. It's a part of learning.

Q. It's according to how much learning he has assimilated during his life?

A. Learning is a form of experience. So, it's related to his emotional development; the types of situations he's been in; the amount of schooling he's had. Many things.

MR. CLARK: That's all.

(*Whereupon the witness was excused.*)

## EXAMPLE B—COMPETENCY

A gentleman 68 years of age received psychological evaluation and treatment in a private out-patient psychological setting during two winter seasons. His work was in psychotherapy, remedial reading, and handwriting retraining following a cerebral accident.

Several months after his last direct contact with the clinic, he

died. His will left the bulk of a rather large estate to his wife. An adopted son, who had been partially supported by this patient, even though the son was gainfully employed as a certified public accountant, brought suit against the estate, challenging the will and his small share of the estate on the grounds that his father was incompetent mentally. The following testimony was taken by one of the attorneys for the estate.

In RE ESTATE OF E. X., *Deceased.*

Memo of Conference between Mr. F. Q. and Dr. B., at Tampa, Florida on March 28, 1957.

R. F. Johnson, *Court Reporter*

QUESTIONS BY MR. Q:

Q. Doctor, will you state the nature of your work?

A. I am a clinical psychologist, in charge of a general psychological services clinic, offering professional services in remedial reading, speech and hearing therapy, and psychotherapy, in each of which we do diagnostic work in all of its areas.

Q. You have furnished me a copy of the letter which you wrote to Mr. V, District Attorney, Y, Wisconsin, under date of March 26, 1957. Is that the letter that you wrote to Mr. V?

A. Yes, sir, it is.

Q. It is my understanding that you gave Mr. X thirty-six sessions of psychotherapy and was that not also in remedial reading and other work?

A. Specifically, Mr. X received thirty-six sessions of remedial reading, plus approximately thirty-six sessions of psychotherapy, the remedial reading being received under my direction, and being administered by Mrs. O, who is one of my staff members who specializes in remedial reading therapy.

Q. Who is Dr. W. W., Jr?

A. Dr. W. W., Jr., is a neuropsychiatrist, practicing in Tampa, Florida, who has served as one of our psychiatric consultants.

Q. Will you explain the tests data at the bottom of the first page of your letter to Mr. V.?

A. Our policy in our clinic is to re-evaluate all of our patients re-

gardless of the service that is being rendered every eighteen sessions. The two figures, dated January 14, 1955, and March 7, 1956, constitute the first and final evaluations of Mr. X's reading capacities in relation to his work with our clinic.

Q. That also covers vocabulary?

A. Yes, sir. Would you like for me to interpret those results?

Q. Yes, sir.

A. When Mr. X. first came to our clinic, although his vocabulary, that is the understanding of individual words and their meanings, was at the eighth grade level, his actual reading comprehension or ability to read words in a meaningful way was at the 3.2 level, as indicated by the tests labeled "Reading Comprehension."

We generally assume that it requires a grade level of 3.5 to read newspapers. Periodicals of a popular vein require approximately 4.0 grade level.

When I refer to grade level, I mean the actual retained abilities that would be presented by the indicated number of school years of material.

These results should be interpreted in the light of such research findings as the average verbal comprehension of high school graduates; ten years after graduation is at the latter end of the sixth grade.

Again referring to the letter to Mr. V., our last evaluation of Mr. X indicates vocabulary function at 11.2 grade level, reading comprehension of 8.5 grade level, and speed of reading at the 4.3 grade level.

This would indicate that Mr. X was capable of reading and thoroughly understanding all but the most involved technical literature, although somewhat slowly as indicated by the speed of reading score of 4.3.

Q. When you say "all but the most technical literature," do you include in that documents of legal nature or are you speaking more of mathematical?

A. I would be specifically speaking of scientific types of literature where the terminology and the words would be relatively unknown to the average person's vocabulary. In my opinion, Mr. X was quite capable of reading and understanding what I would consider normal legal technicalities, since this matter, on occasion, came up for discussion in our psychotherapeutic contacts, such as contracts, matters involving stocks and bonds, legal title for automobiles, and I believe, on several other occasions, it is my opinion although I have no measurements to substantiate that, that Mr. X. was as capable as the average adult and perhaps a bit more so of comprehending and understanding legal documents.

Q. You are speaking now as of March 1956?

A. Yes, sir, at the last time I evaluated Mr. X.

Q. Had he shown great improvement during that entire period?

A. We considered Mr. X. one of our model cases. We have done a fairly consistent amount of work with persons in the senior years who had suffered cerebral accidents such as strokes or hemorrhages. We have noted that most of these people are capable of recovering a good deal of their psychological losses. We felt that Mr. X was the leader among the group that we had studied and helped rehabilitate.

Q. In talking with some other people they indicate that he was not quite sound. They apparently judged this by the manner of his walking and other mannerisms. Would those mannerisms have affected his mental capacity in your judgment?

A. This essentially is a question of medical opinion, but I feel qualified to make at least a remark, since we do have medical consultation in our clinic, and in fact Mr. X was examined by our consulting neuropsychiatrist. Dr. W. W. Jr., reporting his examination, indicates and I quote: "The only neurological loss is in fine movements with the hands."

Mr. X. was a large, heavy-set man. I believe that he probably found some difficulty in walking with a stride, but I cannot honestly indicate that my opinion is that his gross motor movements indicated any lack of intellectual capacity.

Q. In discussing this with you before, you mentioned that he sometimes talked spontaneously on a matter but was more deliberate in his planning. Will you explain that?

A. I had the opportunity to learn a considerable amount about Mr. X.'s personal life and his emotional reactions as the result of our psychotherapy.

Psychotherapy is a situation where an individual expresses his feelings, his thoughts and ideas, and often reviews a good deal of his life's history, the entire purpose of which is to give an individual a better understanding of himself in order that he may better deal with the stresses and strains he may be facing from an emotional point of view.

Our work with brain injured senior citizens has shown that almost all of them suffer a mild situational depression at the time of their accidents. The depression is based on emotional feeling that this may mean the end of their productive and useful life.

We have found that the rehabilitation proceeds more effectively and rapidly if supportive psychotherapy is made a part of the program.

Q. What I had in mind was how—

A. That is preliminary. During the course of our therapy it was noted that Mr. X. was what might be described as an old-fashioned Old-World gentleman. His opinions were very strong and very definite. He could become outraged about matters which he felt affected him personally, whether the matters concerned family, politics, stocks and bonds, women drivers, or what have you.

Mr. X. would express a voluble, intense, and apparently impulsive opinion on many of these matters. I observed, however, that when it came to taking action on anything he was extremely cautious, conservative, and wary.

Q. What was the frequency of your treatments in 1956?

A. May I check my records just a moment?

Q. Yes, sir.

A. During the six to eight weeks Mr. X spent with us in 1956, I had a total of eight formal psychotherapeutic sessions and three informal chats with him.

Q. What was the date of the last one?

A. The date of my last formal contact of a psychotherapeutic nature with Mr. X. was on March 9, 1956, at which time I have the note, "36th session."

Q. You had a letter from him which you showed me dated March 23. Do you intend to furnish us a copy of that?

A. Yes, sir. I will be glad to provide you a copy.

Q. Will you attach that to the memorandum?

A. Now, I saw Mr. X perhaps a half a dozen times following the March 9 contact, informally, for a few moments. It was my policy to meet him in the waiting room, chat a few moments before he would start his remedial reading work with Mrs. O and, of course, I had a fairly formal parting the day he left.

Q. Well, when did he leave?

A. The last clinical contact of a personal nature with Mr. X is dated March 26. At that time, he saw Mrs. O for his last session of remedial reading. Would you like to hear this note? It may be of interest.

Mrs. O's note which is required after each session states: "Mr. X has decided to report to the clinic for two more sessions. He does not leave until next week. He was feeling very well and his attitude has improved a hundred per cent."

Q. Does the letter which he wrote to you indicate anything to you?

A. I feel that it does. Part of our initial evaluation is the handwriting evaluation where brain injury is concerned.

The first evaluation of Mr. X's handwriting was in 1954 and it is

dated July 2. I believe this is approximately one year following his cerebral accident. I believe that most neurologists agree that it is the first year to eighteen months following the accident that the greatest disability tends to occur.

When examining his handwriting at that time, we found he could write his name quite adequately, but that he had great difficulty in making individual letters, such as *O*, *E*, and so forth.

The letter which he wrote to me in 1956 indicated that he has regained the use of handwriting and that he was able to communicate, not only verbally, but in writing at a very competent adult level.

Q. You received reports from Mrs. E. H. I understand that she was treating him under your supervision at Y, Wisconsin, in the summer months; is that correct?

A. I would qualify the word *treating*. She was administering remedial reading therapy under our supervision, which is a relearning process. We sent the material to be used. Mrs. H. is a trained teacher. She followed our directions very implicitly and explicitly, and at the end of her work with Mr. X, administered a series of standardized tests to determine what progress had been made. These were forwarded to us for evaluation. I have a report dated July 28, 1955, which in an objective way helps to indicate the effectiveness of Mrs. H's work with Mr. X.

Q. What was the date of her last report?

A. The date of Mrs. H's last report was August 6, 1956. At this time she indicated that Mr. X had passed away and that at the time of his demise he still engaged as actively as possible in continuing his remedial work.

Q. Was there any further improvement beyond March 7, 1956 as shown in your letter to Mr. V, according to her reports?

A. The improvement would be of a subjective evaluation nature, by Mrs. H, but nevertheless valuable. By that I mean he was not ready for his next test, but she did make comments as to his work. She indicated that they had reached a point where he was keeping a sort of diary for each lesson period with the intention of sending this actual work data to us later. This was done on his own responsibility.

Mrs. H indicated that during the time she worked with him, a relatively short period of time in 1956, that Mr. X was continuing his progress.

I have a note that I wrote to Mrs. H, April 10, 1956, forwarding a large supply of materials and planned work for Mr. X that amounts to a high school level. We felt that he was ready to go into this, both in his reading and his arithmetic.

I indicated to her that now he has begun to make progress and is very impatient to proceed rapidly and that her most difficult job would be to hold him down, so to speak, because he wanted so much to forge ahead.

Q. He was looking forward to going back to his—?

A. Yes, sir. Mrs. H's only complaint about working with Mr. X was that he was a fairly demanding person and he really wanted to take on more than he was able to handle at the time; he wanted to forge ahead.

Q. How far apart were these sessions?

A. These varied, but generally his sessions were three times a week. Occasionally, if he was making a trip or if he decided to go somewhere or he wouldn't feel well, he would skip a session, but three times a week was regular.

Q. And Mrs. O, did you give us her name?

A. Mrs. R. P. O.

Q. She is in your office?

A. Yes.

Q. Was there any further improvement after March 7?

A. I feel there was, but as I say, we don't have any tests.

At this point I'm sure that every professional psychologist reading the previous testimony will have a good deal of criticism covering many areas mentioned in the transcripts. These verbatim records present testimony by two competent clinical psychologists, *Example A* illustrating testimony with minimum preparation and *Example B* presenting testimony where rather careful preparation was possible. Many obvious errors, questionable statements, and omissions will be noted. These illustrations are presented to indicate what is *likely* to occur when a clinical psychologist is called upon as an expert witness. A review of these examples of direct testimony should be helpful before a psychologist's first appearance as an expert witness.

# Part IV

# ADDITIONAL CONSIDERATIONS

# CHAPTER 14

# Research in Private Practice

IT HAS been informally estimated that very little research goes on in the private practice setting (2). To evaluate the present status of this idea, three psychological journals, *The Journal of Consulting Psychology*, the *Journal of Abnormal and Social Psychology*, and the *Journal of Clinical Psychology* were examined, all issues, for the year 1957. *Not a single research article is reported by a clinical psychologist primarily in private practice.* Admittedly this is an amazing, if not disgraceful, reflection on those of us in private practice. Whereas the bulk of research, empirical as it may be, comes from practitioners in medicine, law, and other professional groups, apparently very little is produced by clinical psychologists in private practice. This question must be considered in some detail.

## REASONS FOR LACK OF RESEARCH

The private practice setting is most demanding of both time and energy. The clinician in private practice must not only see his patients but also administer his office, maintain lines of professional

communication and liaison, and generally participate in community and civic affairs.

Facilities for research are minimal. The psychologist in individual private practice is likely to have a difficult time obtaining even a calculator, let alone IBM equipment and expert statistical advice in formulating research designs and processing data. By and large, research in the private practice setting must take place during free evenings, on week ends, and over necessarily long periods of time. The task of research must, therefore, fall to the most energetic and dedicated of the clinical psychologists in the private setting. So much for the barriers.

## THE NEED FOR RESEARCH IN THE PRIVATE SETTING

Certain unique features of the private practice setting make it important that research begin to be formulated there. Whereas most psychological research in the clinical area is cross-sectional, psychologists are well aware of the need for carefully planned longitudinal studies. Certainly some of these are being done in university and institutional settings. Still, relatively little is known of the long-range effect of psychological evaluations, recommendations, and psychotherapy. Such information can be available for study to the stable clinical psychologist who remains in practice in his community for more than a year or two. The opportunities for follow-up and re-evaluation are considerable.

Perhaps of greatest importance is the wide range of behaviors in the community setting which can be studied. No university clinic or mental hospital can provide the *range* of normal, near normal, and abnormal life situations that are seen over a period of time in the private practice setting. The following are examples of research possibilities where the material and situations are readily available in the private practice setting.

1. The intellectual performance, aptitudes, social adjustment, and personality development of normal preschool children who later succeed in elementary school.

2. The long-term effects of direct recommendations to parents of disturbed children on the adjustment of both children and parents.
3. The relationship of behavior disorders in children to personality traits of their parents.
4. The role of the inadequate father-figure in immaturity reactions in children.
5. The effect of group psychotherapy on the long-term social adjustment of juvenile delinquents.
6. Long-term psychological and physical effects of psychotherapy on the more common psychosomatic disorders.
7. Effects of parent-education programs on the social, emotional, and educational adjustment of children.
8. The effect of group psychotherapy on the emotional and social adjustment of wives of men in hazardous occupations.
9. Long-term effects of premarital counseling in senior high schools on the eventual marital adjustment of the participants.
10. Therapeutic factors in the emotional and social adjustment of senior citizens.

Although the age range in the small number of research problems suggested above is extensive, primary emphasis will be noted on the early developmental years. Why not? We generally accept the great influence of the early years on adult emotional adjustment. Little long-range research *or* treatment occurs in these early years. By dint of his training and experience, the clinical psychologist in private practice is in an excellent position to investigate these urgent yet neglected areas of research.

Whether simple mean or rotated factor analysis is the statistic used, the most important aspect of research is always the hypotheses developed and the samples available for testing these. Perhaps better than other clinical psychologists, the psychologist in private practice has the experiences and situations which *could* produce rich and meaningful research.

# CHAPTER 15

# Group Practice

ALL THAT has been discussed to this point has to do with the *individual* clinical psychologist in private practice. Though individual private practice is a useful function for clinical psychologists, group private practice settings have been organized, and the experiences resulting from these seem challenging. All that has been said about individual private practice is applicable to a group setting. Although there are certain organizational, financial, and administrative difficulties when a group of psychologists practice together, the advantages of such an arrangement seem to outweigh the disadvantages. Let us consider the particular advantages in detail.

## A COMMUNITY NEEDS A VARIETY OF PSYCHOLOGICAL SERVICES

If we were to evaluate the psychological needs of a community we would find them multifold. Although psychologists often con-

sider themselves quite capable and effective in many different areas of professional practice, they have areas of greater interest or ability in diagnosis, therapeutic contacts, work with children, adults, and the like. The community, however, has needs for services other than these primarily clinical functions.

If we were to review the service requests in the private practice setting over a period of a year or so, we would find the following services frequently requested.

Vocational guidance
Child development problems
Diagnostics
Psychotherapy
Preschool evaluation
Marriage counseling
Personnel selection
Industrial training
Motivational research
Leadership training
Consumer research
Executive development

This is by no means the entire list, but merely indicates the variety of commonly requested services.

Although a single psychologist may feel himself to be competent in all of these areas, it is questionable whether one could be a specialist in even a small number of them. Thus, an individual psychologist in private practice would offer services where he feels competent. The remainder of his referrals would have to be sent to other professional people if they are available. It is found that a wide variety of psychological services rarely exists except in the larger cities. Even where these services are available in large communities, there is likely to be a great need for additional services in the categories mentioned above.

From the point of service to the community, the psychological

setting which offers a variety of services is desirable. A community can be better served by a group private practice setting wherein each psychologist tends to specialize in certain areas where his background training and interests are appropriate.

## ADMINISTRATIVE FACTORS

Most psychologists are relatively naïve concerning the basic clerical and administrative functions which must go on in any kind of a business or professional setting. Secretarial help, the keeping of books, answering of telephones, the keeping of schedules, the organization of individual fee situations, and other administrative matters must be considered whenever services are offered for a fee. Whether an individual is practicing privately or with a group of psychologists in joint private practice, all of these administrative details must be attended to.

There are certain opportunities in a group setting for the multi-purpose use of clerical and administrative help. One secretary can be used as bookkeeper and general administrative head of clerical matters. This will take a considerable burden off the psychologist and enable the operation to function more smoothly. Psychologists are quite verbal and their reports tend to be long and technical. This requires a secretary whose primary skills and duties are typing and production. Seldom will one find a bookkeeper who can be an excellent production typist. In the group setting, a variety of clerical assistants can be hired, and always be kept reasonably busy by the varying demands of the individual professional people in the group.

Office space is rented or leased on the basis of square foot-per-year-cost. This means that for each additional professional person a certain number of square feet of office and working space will be necessary. Certain areas of office space can be shared by a group of professionals. The waiting room, storage room, file room, secretarial space, and group therapy or testing rooms can serve a number of professional people, and therefore help to keep overhead costs at a minimum.

Where income versus overhead is concerned it has been found possible to set more flexible fee schedules in a group practice than in an individual setting. The individual psychologist must produce a greater income to pay expenses (because of the higher overhead) than each individual in a group practice.

It has been noted that in a group private practice setting between 30 and 40 per cent of services can be rendered on a low fee or a community service basis. This is seldom, if ever, possible with the individual psychologist in private practice.

Somewhat associated with the question of fees are vacations and "time off." Most psychologists in private practice take few vacations, particularly during the initial five to ten years of their practice. It is difficult to close the office for several weeks, taking no referrals, intakes, and being unable to perform services. Most people accept the fact that everyone needs a vacation, but with individuals who are in need of help, this tends to be a minor consideration in their thinking. In the group practice setting vacations may be alternated and thus there would always be professional help available for those people who call. The group becomes known as a constantly functioning operation which does not have breaks or delays because of the individual time requirements of the professional people. In the matter of attendance at professional meetings, post-doctoral training, and conventions, the participants can alternate their attendance and yet maintain the office. The larger the group the more flexible can be the administrative details.

There are additional benefits and savings in terms of occupational licenses—municipal, county, and state—group insurance plans, and professional prestige.

## PROFESSIONAL ADVANTAGES

By and large psychologists are trained in an academic and scientific tradition which deplores working in isolation. As indicated earlier, the individual psychologist in private practice can maintain professional liaison and contact with other psychologists. At best, however, this is difficult.

The group private practice setting automatically provides the opportunity for professional interrelation, continued training, and a better perspective on one's individual role.

In the group setting, staff meetings become a regular part of the weekly professional routine. These staff meetings not only directly help to provide more adequate service to patients, but offer a continuing opportunity for in-service training and refinement of professional skills. The personal satisfactions from such meetings are quite beneficial. The relationship which exists among a group of psychologists in private practice tends to be much closer than can be found in other professional settings. Here we would find a group of people who have begun a venture together, are the sole owners of the venture, and are working for their mutual good as well as their professional satisfaction. Group settings have been found to be very warm, productive, and creative.

The question of liaison with other professional people is particularly important. Whereas a clinical psychologist in individual private practice may be able to make some arrangements with a psychiatrist for consultation and collaboration, this is difficult, expensive, and too often temporary. In the group private practice setting, where there are several clinical psychologists working together, it is easier to select a highly competent psychiatric consultant and to hire him on a fee basis for regularly scheduled psychiatric staff meetings.

It is always preferable to pay for these consultantships. The psychiatrist who occasionally consults with a group on a friendly basis is not likely to be able to give his services in a professional and regular manner. The regularly scheduled psychiatric consultant who is paid a reasonable fee for his consultation should be able to justify his fee with suggestions and recommendations. Whereas this would be prohibitively expensive for an individual psychologist in private practice, several clinical psychologists who practice together are well able to afford these weekly consultation fees, and still get very individual and specific benefit from such meetings.

## ANCILLARY SERVICES

The group private practice setting may expand beyond the offering of purely psychological services. Classically, in universities and clinics, clinical psychology services have been offered in conjunction with or in co-operation with speech therapy, audiology, speech training, rehabilitation functions, remedial reading, and educational guidance. The group practice in psychology offers an excellent setting for ancillary services. The need for such services often develops from diagnosis of a problem which seems to be primarily psychological in nature. Thus the child who is exhibiting behavior difficulties may be found to be a bright youngster who has, for one reason or another, missed fundamental reading skills during the early years of schooling. Whereas a therapeutic program for the child as well as a counseling program with the parents would seem well advised, remedial reading for the child may help in an earlier completion of the therapeutic program.

Certainly it is feasible for an individual psychologist in private practice, when he comes upon a case which needs both speech therapy and psychotherapy, to refer the patient for the speech therapy to another installation, if such a service exists in the community. It is generally agreed that in multiple therapy liaison between joint therapists is quite necessary. Again this is possible with the lone psychologist in private practice, but it is a difficult thing in terms of administration, time, and co-ordination. In the group setting, where such ancillary services are directly available, regular staff meetings and consultation time provide effective contact where cases are handled in joint therapy. Occurring this way the value of service to the patient is increased.

## ORGANIZING THE GROUP SETTING

The preliminary steps in organizing a group private practice must be worked out through long and careful planning. Someone, of course, must bring together a group of interested psychologists

who are willing to discuss the possibilities of such an arrangement. During the initial planning sessions, certain factors should be considered: the qualifications, interests, and abilities of the particular psychologists who are thinking of associating themselves together are most important. This will serve to define the kind of services which can be offered. Although needs of the community should be considered and, indeed, this would be an important part of the planning stage, the primary considerations must be the skills and professional abilities which can be offered by members of the group. This will lead into the question of the communities' needs for psychological services. An analysis of community needs can be made in a number of ways. The interested psychologists may have lived and worked in the community, and thus be aware of the presence or absence of psychological services. Resources of local agencies for handling general psychological problems, the size of the waiting list in local child guidance agencies, consultation with the Better Business Bureau, Chamber of Commerce, and, where such an organization exists, the Community Co-ordinating Council will help develop a fair picture of the psychological needs of the community.

A good source of information to enable one to estimate community needs for psychological services can be found in the Civic Clubs of the community. The officers of these clubs are often aware of the community's needs for specific professional services. Consultation with local psychiatrists and medical people as well as with authorities of the school system can be helpful in determining the potential for a group private practice.

The next step in the planning would be a detailed discussion of the kind of setting which will be developed. Changes will be made with experience, but a carefully planned idea of the kind of setting, both physical and professional, should be determined before any action is taken to begin the practice. The kind of offices needed, the amount of space necessary, the availability of such space, and other factors are very important in planning. Some detailed investigation will have to be made as to where the offices might be

located. Some indication of rental cost and lease requirements will have to be made.

When the planning has reached this stage the sources of initial capital must be considered. By this time the planning should have gone far enough to give the partners of the potential group some idea of what their initial capital investment will have to be. Furniture, fixtures, stationery, and equipment are relatively minor in respect to the question of living expenses for the first year or so of practice. It would be conservative to anticipate making no profit during the first year of operation, and therefore plan to have a year's income available from some source. Does this mean then that three young psychologists planning a private practice setting must have $20,000 in the bank before they can begin their group setting? The answer of course is no, as it would be in any business or commercial enterprise. Professional people of good character and stable background are well able to call upon their credit to raise capital for an enterprise such as a group private practice. This will involve the entire group formulating their plans and taking them to one of their local banking institutions. The group will be asked their definite needs, their projected plans, and the type of arrangement they would like to have in terms of the money being borrowed. A portion of the capital may be borrowed on a long-term loan, wherein collateral may be given. Interest rates are lower for such loans. Additional capital may be borrowed on short-term loans, generally ninety days renewable, with a slightly higher interest rate.

When arrangements have proceeded this far it is time for the group to sit down and plan their own financial arrangements in terms of fees received, the salaries to be paid, and the division and allocation of profits. At this point the group should consult an attorney for recommendations, contracts, or agreements.

In planning for potential growth and development of the practice, the question of whether the group shall be a partnership, a limited corporation, or a corporation must be considered. Each has its specific advantages and disadvantages. In order to decide

what form of group will be established, the objectives and goals must be as clearly defined as possible. There are certain distinct advantages that can be best explained by an attorney. A lawyer will handle such items as corporation papers, partnership papers, banking arrangements, occupational licenses, and the like with dispatch. It is at this time that the partnership should consider taking out liability and malpractice insurance.

Should the partners arrive at this point, still maintaining their enthusiasm for a group private practice setting, space should be rented, contracts signed, and the practice initiated.

# CHAPTER 16

# The Predictable Future

PRIVATE PRACTICE in clinical psychology is now a reality. It can be described, and the purpose of this book has been exactly that. It is questionable whether there is a city in the United States which has adequate service for the evaluation and treatment of psychological problems. This is not simply a matter of the number of psychologists who are at present serving communities in either guidance centers, hospitals, clinics, or courts, but a question of where professional service is still needed. At the present time the major effort of psychological work is not given at the community level, but in institutions, in research, and at the university. Relatively little work is being done in applying what knowledge is available to the relief of the *source* of adult emotional disturbances. This can be a primary function of the individual clinical psychologist in the private practice setting.

Training of clinical psychologists at university graduate schools continues. Psychology has shown a continued growth as a desirable profession for young, intelligent people.

The university graduate school implants and cultivates the basis of ethical standards and general professional attitudes for future professional psychologists. Few people who become interested in private practice do so with initial feelings of assurance that this is a highly regarded field for the use of professional psychological skills. The trend is changing, for as more experience is gained in such settings, interest and approval from graduate school faculties will also grow.

If we are to assume that private practice is an ethical and necessary function for clinical psychologists, what can be done to encourage wider participation at this community level? The beginning must be made at the university. In all probability, both graduate training programs and internship-resident opportunities will intensify their emphasis on experience with responsibility for individual patients. To be sure, many training institutions now offer such an emphasis. Too many training facilities, however, still give psychologists an opportunity to become a more expert "mental tester" or a better research person without encouraging and supervising the individual relationship with patients. This need has been clearly described recently (*82*).

A closer relationship between the scientific and professional practice aspects of psychology is emerging. Continual training and professional growth opportunities will probably begin to appear. The postdoctoral training institutes sponsored by the American Psychological Association have been most successful in this direction and opportunities will probably be broadened by more frequent offering of advanced professional training at the major universities.

Viewing the growth of psychology in the past ten years, one can anticipate increased effort among the graduate schools, the American Psychological Association, and state psychological associations to provide more stringent selection procedures for people who will be trained and then sent out to represent psychology as a science and profession. Continued efforts judicially

and within the profession will be made to establish standards for adequate practice.

These efforts will lead to a closer liaison between psychologists in training and research and those who use psychological experience and research findings in actual patient relationships. This will constitute an opportunity for "feedback," which will undoubtedly benefit both the academician and the practitioner (*82*).

Private practice in clinical psychology requires intense energy, an excellent educational and experience background, personal maturity, and a strong sense of individual responsibility. People possessing these traits are regularly emerging from our graduate training programs in clinical psychology. Thus the trained personnel are available, the communities have a definite need, and it would seem inevitable that the private practice function for clinical psychology will become a significant application of professional psychological skills.

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# Appendix

# APPENDIX A:

# DIRECTORY MATERIAL

The following directory material will provide a basic reference library that may be used in many situations, primarily those involving the planning for disposition of cases after evaluation. Ordinarily these directories are revised every one to three years, and the psychologist should be certain that he has current directories available.

## DIRECTORY OF THE AMERICAN PSYCHIATRIC ASSOCIATION

*Published by the American Psychiatric Association, 1785 Massachusetts Ave., N.W., Washington 6, D.C.*

Published at the time of the annual American Psychiatric Association meetings, this directory lists the fellows, members, and life members of the American Psychiatric Association. In addition to the listing of name and address, designation of specialty, designation of Diplomate status, and officers of the Association is made.

## DIRECTORY OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

*Published by the American Psychological Association, Inc., 1333 Sixteenth St., N.W., Washington 6, D.C.*

Published annually, listing psychologists who are members, fellows, and life members of the American Psychological Association. The directory lists the specialty of the individual psychologist insofar as Diplomate of the ABEPP is concerned, as well as divisions to which the individual belongs. Approximately once every three years, the full background, education, work history, and special interests of each psychologist is listed.

## THE DIRECTORY OF AMERICAN PSYCHOLOGICAL SERVICES

*Published by the American Board for Psychological Services, 10 East Sharon Ave., Glendale, Ohio.*

This directory, published by an agency sponsored by the American Psychological Association lists individuals and clinics providing essentially psychological services for emotionally disturbed children, adolescents, and adults, vocational counseling, and industrial psychology. Each listee has been carefully investigated by a team of evaluators from the American Board of Psychological Services. Listed is the address of the agency, the sponsorship, services offered, type of clientele, fees, method of application, the director's name and background, the hours, and any branch offices.

## DIRECTORY OF THE AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY AND PSYCHODRAMA

*Ordinarily published as part of the March issue of the journal* Group Psychotherapy.

This directory lists the members and fellows of the American Society of Group Psychotherapy and Psychodrama.

## DIRECTORY OF COMMUNITY CHEST AND COUNCILS OF AMERICA

*345 E. 46th Street, New York 17, New York.*

This directory lists the national staff of the Community Chest and Councils of America, the officers and directors of the Association, the individual Community Chest organizations by state, listing the director, the address, the annual goal, and the amount raised for the previous two years.

## EDUCATIONAL DIRECTORY–COUNTIES AND CITIES

*Published by the U.S. Department of Health, Education, and Welfare, Office of Education, Washington 25, D.C.*

This four-part pamphlet published annually lists the superintendents, presidents, and directors of federal government and state schools,

county and city schools, institutions of higher education, and educational associations.

## DIRECTORY OF PSYCHIATRIC CLINICS AND RESOURCES IN THE UNITED STATES

*Published by the National Association of Mental Health, Inc., 1790 Broadway, New York 19, New York.*

This directory lists public (city, county, state, or federal) supported mental health clinics for either children or adults or both throughout the United States. Listing is by state, and included are the names of the state hospitals. The address of each clinic, the director, the staff, hours, and case loads for the previous year are listed.

## DIRECTORY FOR EXCEPTIONAL CHILDREN

(Educational and Training Facilities)

*Published by Porter-Sargent, 11 Beacon Street, Boston 8, Massachusetts.*

A directory for schools, clinics, and other services available throughout the United States and Canada for the emotionally disturbed, brain injured, handicapped, mentally defective, and other special-need groups. State schools are also listed. The listing by state indicates the name of the school, location, address, director's name and background, extent of the staff, fees, and types of services offered.

## DIRECTORY OF PRIVATE SCHOOLS

*Published by Porter-Sargent, 11 Beacon Street, Boston 8, Massachusetts.*

This directory lists all the private schools in the United States. The name of the school is listed, type of facility whether boarding or day school, indication of whether the school is co-educational, and approximate proportion of boys and girls is listed. The address, the director and his background, the type of work offered, the extent of the physical plant, the number of recent graduates, as well as the percentage of these which entered college, and details as to the type of program are offered. An indication of the basic tuition fees plus extras is indicated.

## PUBLIC SCHOOL PERSONNEL DIRECTORY

*Ordinarily published by the County School Office.*

This directory lists the address of each school, elementary and secondary, giving the principal's name and home address, and listing each individual teacher.

## DIRECTORY OF RESIDENTIAL TREATMENT CENTERS FOR EMOTIONALLY DISTURBED CHILDREN

*Printed by U.S. Government Printing Office, Washington 25, D.C.*

This directory lists the various therapeutic treatment centers for children throughout the United States. For each center they list the address, the director, general admission policies, physical plant, staff, service program, and fees.

## DIRECTORY OF SERVICES FOR CHILDREN

(State)

Ordinarily obtained from the Children's Commission or the Children's Bureau of a particular state, this directory indicates the institutions, special services, and departments which have to do with services for children, ordinarily of a social, remedial, or welfare nature.

## DIRECTORY, SOCIETY FOR PROJECTIVE TECHNIQUES AND RORSCHACH INSTITUTE, INC.

*Published by the Journal of Projective Techniques, 210 E. Wilson Avenue, Glendale 6, California.*

Ordinarily published as part of the March issue of the *Journal of Projective Techniques*, although available as a separate reprint, this directory lists the members, fellows, and charter members of the Society for Projective Techniques and the Rorschach Institute. Membership of this organization is restricted to those people who use projective techniques regularly and who have by endorsement demonstrated confidence in the use of these techniques.

## DIRECTORY OF SUMMER CAMPS

*Published by Porter-Sargent, 11 Beacon Street, Boston 8, Massachusetts.*

A carefully compiled list of summer camps which have been long established, providing the name of the camp, the director's name and address, the location of the camp, camp capacity, fees, and the general nature of the camp. Cross indexed. Covers the entire United States and Canada.

## THE DIRECTORY OF WELFARE, HEALTH, AND RECREATIONAL SERVICES (Local)

Issued individually in various cities, this directory usually indicates the address, the executive director's name, and a general description of the services offered on a local level.

# APPENDIX B: FORMS, FORM LETTERS, AND PROCEDURES

## INTAKE FORM

Name Richard Roe Date 5-15-57 by J. P. D.

Address 327 Prospect Drive Telephone 2-3742

Birthdate 3-27-24 Age 33-2 Occupation Salesman

Referred by Self

REASON FOR REFERRAL: Mr. Roe telephones stating that he has some "Personal Problems" he wishes to discuss.

5-16-57: During a brief interview pt. indicates that for the past 3 years he has suffered from gastric difficulties with no demonstrable organic pathology. He wonders whether tension may not be the cause since conflict and indecision precede the symptoms. Evaluation recommended.

History: 6-9-57

Diagnostic Eval: 6-11-57

Interpretation: 6-18-57

Test Battery: History, Rorschach, TAT, Sent. Compl., MMPI, Bender.

FEES: Diagnosis: $90 Therapy: $15/session (income $7000 p.a.)

REPORTS TO BE REQUESTED: Dr. A. Jones, 2843 Main St. (Internist) G.I. series (1955, 1957). 3 years empirical Rx.

REPORTS TO BE SENT: Dr. Jones

# APPOINTMENT CARD AND LETTER

John P. Doe, Ph. D.
Clinical Psychology
111 Professional Row
Gotham, Indiana

Mr. Richard Roe
Has an appointment for

Day Monday Date June 9 Hour 10:00am
Wednesday June 11 1:00pm
Wednesday June 18 10:00am

This time has been reserved for you. If for any reason you cannot keep the appointment please phone 8-7654 at least 24 hours in advance.

John P. Doe, Ph. D.
111 Professional Row
Gotham, Indiana

Diplomate, in Clinical Psychology
American Board of Examiners
In Professional Psychology

Telephone 8-7654
Hours by Appointment

Mr. Richard Roe
327 Prospect Drive
Gotham, Indiana

May 18, 1958

Dear Mr. Roe:

In reference to our discussion on May 17th, I have made a series of appointments for you as noted on the enclosed appointment card.

Should any of these times be inconvenient for you, please call and we will try to make more suitable arrangements.

Looking forward to meeting with you on June 9th, I am

Sincerely yours,

John P. Doe

John P. Doe, Ph.D.

# FORMS REQUESTING RELEASE OF REPORTS AND PERMISSION TO FORWARD REPORTS

PERMISSION TO RELEASE
CONFIDENTIAL RECORDS

To: Albert Jones, M.D.

2843 Main St.

Re: Mr. Richard Roe

Permission is hereby given to release any information about the above named person to Dr. John P. Doe, 111 Professional Row, Gotham, Indiana.

Signed Richard Roe

(Relationship) —

Date 5-17-57

PERMISSION FOR
RELEASE OF INFORMATION

This is to authorize Dr. John P. Doe to release any information including test results regarding

Richard Roe

Signed Richard Roe

Relationship to Patient —

Reports to: Dr. Albert Jones
2843 Main St.

# COVER LETTER FOR REPORT

John P. Doe, Ph.D.
111 Professional Row
Gotham, Indiana

Diplomate, in Clinical Psychology
American Board of Examiners
In Professional Psychology

Telephone 8-7654
Hours by Appointment

Albert Jones, M.D.
2843 Main Street
Gotham, Indiana

June 30, 1957

Dear Dr. Jones:

I have had the opportunity of examining Mr. Richard Roe, one of your patients. At the request of Mr. Roe, I am enclosing a report of my evaluation.

I have encoureged Mr. Roe to discuss the report and my recommendations with you.

Should you have any questions concerning this report or my work with Mr. Roe, I would be pleased to hear from you.

Sincerely yours,

John P. Doe

John P. Doe, Ph.D.

# BILLHEAD AND BILLHEAD ENVELOPE

If not delivered in 5 days
return to
111 Professional Bldg.
Gotham, Indiana

John J. Doe, Ph. D.
111 Professional Building
Gotham, Indiana

STATEMENT

TO

Mr. Richard Roe
327 Prospect Drive
Gotham, Indiana

AS OF: June 30, 1957

FOR PROFESSIONAL SERVICES:

Diagnostic Evaluation: Interview, Rorschach Test, Thematic Apperception Test, Sentence Completion Test, Bender Gestalt Test, Minnesota Multiphasic Personality Test, Interpretation Interview.

$90.00

# SUMMARY SHEET FOR CLOSING A CASE

**END OF CONTACT**

NAME: Richard Roe Date Case Closed 6-30-58

ORIGINAL INTAKE 5-15-57, Personality Evaluation

ADDITIONAL Referred by Dr. Jones

---

NUMBER OF CONTACTS Diagnostic plus 45 psychotherapy

REASON FOR CLOSING Patient terminated

---

COMMENTS:

Patient reported considerable progress as a result of psychotherapy.

6-30-58 Summary letter to Dr. Jones

7-10-58 Call from Dr. Jones indicating satisfactory progress in relief of symptoms.

8-15-58 Single session to work out change-of-job conflict (See notes)

# PROFESSIONAL ENVELOPES AND RUBBER STAMP FOR REPORTS

John P. Doe, Ph. D.
Clinical Psychology
111 Professional Bldg.
Gotham, Indiana

If not delivered in
five days return to
111 Professional Bldg.
Gotham, Indiana

CONFIDENTIAL MAIL
To be opened by the person named below

CONFIDENTIAL

This report should be made part of the patient's file. Under no circumstance should the report be read or given directly to the patient.

# DAILY APPOINTMENT SHEET

Day _____ Date _____

| Hour | Dr. Jones | Dr. Smith | Dr. Brown | Test Room |
|---|---|---|---|---|
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |
| 11 | | | | |
| | | | | |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| Evening | | | | |

Cancellations _____

_____

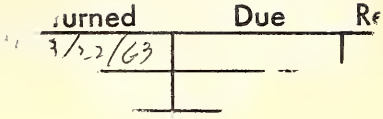
_____

Total this day _____

Total for month _____

To date _____

# Index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3/22/63